Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

Access to Recovery (Short Title: ATR)

(Initial Announcement)

Request for Applications (RFA) No. TI-10-008

Catalogue of Federal Domestic Assistance (CFDA) No.: 93.275

Application Deadline	**Applications are due by March 10, 2010.**

Table of Contents

Executive Summary:

The United States Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) announces the availability of fiscal year (FY) 2010 funds for Access to Recovery (ATR) grants. The ATR grants provide funding to Single-State Agencies (SSAs) for Substance Abuse Services in the States, Territories, and the District of Columbia, Tribes, and Tribal organizations to carry out voucher programs for substance abuse clinical treatment and recovery support services pursuant to sections 501(d)(5) and 509 of the Public Health Service Act (42 U.S.C. sections 290aa(d)(5) and 290bb-2). This program addresses Healthy People 2010 focus area 26 (Substance Abuse).

Funding Opportunity Title:	Access to Recovery
Funding Opportunity Number:	TI-10-008
Due Date for Applications:	March 10, 2010
Anticipated Total Available Funding:	$95.5 million
Estimated Number of Awards:	Up to 30
Estimated Award Amount:	Up to $2 million - $4 million
Length of Project Period:	Up to 4 years
Eligible Applicants:	Eligible applicants are the Single-State Substance Abuse Agencies in the States, Territories, and the District of Columbia; and the highest ranking official and/or the duly authorized official of a federally recognized American Indian/Alaska Native Tribe or Tribal organization. [See Section III-1 of this RFA for complete eligibility information.]

I. FUNDING OPPORTUNITY DESCRIPTION

1. INTRODUCTION

The United States Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) announces the availability of fiscal year (FY) 2010 funds for Access to Recovery (ATR) grants. The ATR grants provide funding to Single-State Substance Abuse Agencies in the States, Territories, and the District of Columbia, Tribes and Tribal organizations to carry-out voucher programs for substance abuse clinical treatment and recovery support services pursuant to sections 501(d)(5) and 509 of the Public Health Service Act (42 U.S.C. sections 290aa(d)(5) and 290bb-2). This program addresses Healthy People 2010 focus area 26 (Substance Abuse).

The Access to Recovery (ATR) Program is designed to provide client choice among substance abuse clinical treatment and recovery support service providers, expand access to a comprehensive array of clinical treatment and recovery support options (including faith-based programmatic options), and increase substance abuse treatment capacity. Monitoring outcomes, tracking costs, and preventing waste, fraud and abuse to ensure accountability and effectiveness in the use of Federal funds are also important elements of the ATR program.

Through the ATR grants, the Single-State Substance Abuse Agencies in the States, Territories, and the District of Columbia, Tribes and Tribal Organizations (hereinafter collectively referred to as "SSAs/Tribes/Tribal Organizations") will have flexibility in designing and implementing voucher programs, consistent with proven models, to meet the needs of clients in their target regions. A major goal of the ATR program is to ensure that clients have a genuine, free, and independent choice among a network of eligible providers. SSAs/Tribes/Tribal Organizations are encouraged to develop provider networks that offer an array of clinical treatment and recovery support services that can be expected to result in cost-effective, successful outcomes for the largest number of people.

Current and former ATR grantees, as well as entities that have not received an ATR grant and that meet the eligibility criteria, may apply. (See Section III-Eligibility Information for additional information about eligibility for the ATR program.) Current grantees must propose to enhance or expand efforts in the proposed geographic area, client population, services provided, or any other component that was not included in previous grant(s). Applications from previously funded ATR grantees will be subject to evaluation of past performance (GPRA client targets and use of funds as planned in the program budget), among other review criteria **(See Section I-2-Expectations and Appendix M of this RFA)**.

As of February 2009, approximately 1.89 million men and women have been deployed to serve in support of overseas contingency operations, including Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Individuals returning from Iraq and

Afghanistan are at increased risk for suffering post-traumatic stress and other related disorders. Experts estimate that up to one-third of returning veterans will need mental health and/or substance abuse treatment and related services. In addition, the family members of returning veterans have an increased need for related support services. To address these concerns, SAMHSA strongly encourages all applicants to consider the unique needs of returning veterans and their families in developing their proposed project.

2. EXPECTATIONS

ATR grantees will be expected to use their ATR grant funds to facilitate individual choice and promote multiple pathways to recovery through the development and implementation of substance abuse treatment and recovery support service voucher systems. Multiple pathways to recovery include, for example, the use of anti-addiction medications, faith-based treatment and recovery support services, peer-to-peer recovery support services, among other pathways.

SSAs/Tribes/Tribal Organizations should propose innovative strategies for their ATR projects to accomplish the following program objectives:

- Ensure genuine, free, and independent client choice for substance abuse clinical treatment and recovery support services appropriate to the level of care needed by the client. For the purposes of this grant program, choice is defined as a client being able to choose from among two or more providers qualified to render the services needed by the client, among them at least one provider to which the client has no religious objection.

- Provide all substance abuse assessment, clinical treatment, and recovery support services funded through the ATR grant through vouchers given to a client by an SSA/Tribe/Tribal Organization. No funding shall be given directly to a provider through a grant or contract to provide any services under this program, including assessments. By vouchering services, the ATR program employs an indirect funding mechanism[1].

- Ensure each client receives an assessment for the appropriate level of services and is then provided a genuine, free, and independent choice among eligible providers, among them at least one provider to which the client has no religious objection.

[1] Indirect funding means that individual, private choice, rather than the Government, determines which substance abuse service provider eventually receives the funds. With indirect funding, the individual in need of the service is given a voucher, coupon, certificate, or other means of free agency, such that he or she has the power to select for himself or herself from among eligible substance abuse service providers, whereupon the voucher (or other method of payment) may be "redeemed" for the service rendered. Under "direct" funding, the Government or an intermediate organization with the same duties as a governmental entity purchases the needed services directly from the substance abuse service provider. Under this scenario, there are no intervening steps in which the client's choice comes into play. The government or intermediate organization selects the provider from which the client will receive services.

- Allow eligible clients to use their vouchers to pay for assessment and other clinical treatment and recovery support services from a broad network of eligible providers. The network of eligible providers should include provider organizations that have not previously received public funding. Eligible service providers for the voucher program may include the following: public and private, nonprofit, proprietary organizations, including faith-based and community-based organizations, as approved through established procedures by the SSA/Tribe/Tribal Organization.

- Ensure that faith-based organizations otherwise eligible to participate in this program are not discriminated against on the basis of their religious character or affiliation.

- Maintain accountability by creating an incentive system for positive outcomes and taking active steps to prevent waste, fraud and abuse.

- Expand clinical treatment and recovery support services by leveraging use of all Federal funds, preventing cost shifting, and ensuring that these funds are used to supplement and not supplant current funding for substance abuse clinical treatment and recovery support services in the State. [Note: SSAs/Tribes/Tribal Organizations must include a letter in **Attachment 4** of the application certifying that they will not use ATR funds to supplant current funding if they receive an award.]

In developing applications for the ATR program, applicants must establish a goal for the total number of clients to be served over the four years of the program ("four-years numbers-served goal") and identify key milestones over the four-year grant project that will result in achievement of the four-year numbers-served goal. Applicants should be aware that SAMHSA is seeking to serve 225,000 people over the four years of the ATR program (33,500 in year 1; 70,750 in year 2; 70,750 in year 3; and 50,000 in year 4). Grantees will be held accountable for meeting the milestones they have identified in their applications and contributing to the overall target for the ATR program. If a grantee fails to meet a milestone, future funding may be delayed until the grantee provides evidence that the milestone has been met. Furthermore, failure to meet the clients served target in any year of the program may affect competitiveness for future funding opportunities. Given the 225,000 SAMHSA target for the four years of the program, successful applicants may be asked to negotiate their clients served goals, in total and by year, to comport with the overall target SAMHSA must achieve.

SAMHSA is especially interested in ensuring that the voucher systems supported through the ATR projects include the most cost-effective mix of clinical treatment and recovery support services necessary to achieve intended outcomes. Applicants must include both types of services in their proposed projects and are encouraged to devote substantial funds to recovery support services. In the 2007 cohort of ATR grantees, 48% of funds spent on vouchers were allocated to recovery support services. SAMHSA encourages ATR grantees to continue allocating a comparable level of resources for recovery support services.

For many clients, it will be desirable to provide a full array of services with the emphasis changing as the client moves through the recovery process. For example, in the early, acute phase of the recovery process, greater emphasis may be placed on clinical treatment services. However, when clients complete clinical treatment and enter a maintenance phase, the emphasis may switch toward recovery support services. In some cases, depending on the results of the initial assessment, recovery support services alone will suffice.

Applicants may wish to prioritize the proposed services/target populations (e.g., services for methamphetamine-addicted clients, services for drug court clients, etc.) based on local needs.

SAMHSA is interested in supporting different organizational models to implement substance abuse voucher programs, including, but not limited to the following:

- Full implementation of the program through the SSA/Tribe/Tribal Organization.

- Implementation of the program through public/private partnerships (i.e., a contract between the SSA/Tribe/Tribal Organization and a lead private entity to implement all or part of the program).

SSAs/Tribes/Tribal Organizations may implement the program Statewide, or may target geographic areas of greatest need, specific populations in need, or areas/populations with a high degree of readiness to implement a voucher program. SSAs/Tribes/Tribal Organizations may propose alternate models for consideration, as long as they conform to the expectations articulated above.

SSAs/Tribes/Tribal Organizations are encouraged to minimize the funds used to cover both the direct and indirect costs of administration of the program, to develop a system to manage the program on the basis of reasonable costs, to develop a system to provide incentives to eligible providers with superior outcomes, and to include a broad range of stakeholders in planning and designing their proposal.

Appendix A of this announcement provides hypothetical examples of two projects that conform to these expectations. SSAs/Tribes/Tribal Organizations may wish to consult this appendix as a starting point for developing their ATR grant applications.

Newly funded grantees are expected to fully implement their voucher programs no later than 4 months after the award date. Previously ATR-funded grantees are expected to fully implement their voucher programs no later than 3 months after the award date. **See Appendix B** for a listing of full implementation requirements for new and previously ATR-funded applicants. SAMHSA/CSAT will provide technical assistance to support grantees with meeting these implementation deadlines.

Grantees are expected to maintain four key staff on the grant project: Project Director, Treatment and Recovery Support Services Coordinator, Information Technology

Coordinator, and Fiscal Coordinator. Project Directors are required to commit a minimum of 75% level of effort to implementing the program and cannot be contractors. In addition, the administrator of the SSA/Tribe/Tribal Organization is required to devote 5-10% level of effort to the oversight of the project on an in-kind basis.

The ATR program encourages innovation in the organization, delivery, and financing of clinical treatment and recovery support services. Therefore, you must propose to develop and implement a program that addresses each of the following components:

- Developing and maintaining an electronic voucher management system.
- Eligibility determinations for clinical treatment and recovery support service providers and for which service in the continuum of recovery will be included in the voucher reimbursement system.
- Eligibility determinations for clients, including management of a system for assessment and service determinations.
- Identifying and determining eligibility of new clinical treatment and recovery support service providers.
- Fiscal/cost accounting mechanisms that can track voucher implementation.
- Management of information systems to track performance and outcomes.
- Outreach to and partnership with grass-roots community- and faith-based organizations or other entities unknown to the SSA/Tribe/Tribal Organization.
- Infrastructure development and sustainability planning among enrolled community-based and faith-based organizations.
- Developing information technology capacity to upload performance data to SAMHSA. (Training and technical assistance will be offered on data collecting, tracking, and follow-up, as well as data entry).
- Development of a client follow-up system in order to find and interview clients six-months post-intake.
- Activities to attract, develop, and sustain new clinical treatment and recovery support service providers.
- Oversight of standards and clear procedures to monitor, prevent and remediate fraud, waste and abuse.
- Establishment of referral pathways and collaborations with other large institutional systems such as the criminal justice system, State Departments of Corrections, probation, parole and jail authorities. This may include assistance with developing Memoranda of Understanding (MOUs) and other formal mechanisms to solidify client referrals.

Prior to the application deadline, SAMHSA will offer pre-application technical assistance (e.g., face-to-face meetings, live webinars) to interested applicants. A Frequently Asked Questions document will be developed based on pre-application technical assistance activities and posted on the ATR website at http://atr.samhsa.gov/. Additionally, shortly after the publication of this RFA, applicants may submit questions to http://atr.samhsa.gov/RFAquestions and the answers will be posted on the ATR website. Please note, any questions posted within 72 hours of the application deadline will not be

answered. Upon grant award, SAMHSA also will make available a broad range of technical assistance related to the above requirements.

Past Performance Evaluation of Previously ATR-Funded Applicants

For applicants who have previously received an ATR grant (under either the 2004 or 2007 ATR grant program), reviewers will evaluate past performance on two measures: (1) meeting the target for the number of clients served, and (2) use of funds as planned in the program budget. Applicants will be required to submit data (to be furnished by SAMHSA) on these measures as part of their application. Reviewers will assign points based on the past performance data during the review as explained in **Appendix N.** For additional information on past performance evaluation, please contact Deepa Avula, Team Leader, Performance Measurement Branch, at (240) 276-2961 or Deepa.Avula@samhsa.hhs.gov.

2.1 Data Collection and Performance Measurement

The Government Performance and Results Act of 1993 (P.L.103-62, or "GPRA") requires all Federal agencies to set program performance targets and report annually on the degree to which the previous year's targets were met. Agencies are expected to evaluate their programs regularly and to use results of these evaluations to explain their successes and failures and justify requests for funding. SAMHSA has established the performance targets for the ATR program. These targets will be reviewed, and may be revised, based on information provided in funded grantees' applications. Grantees will be expected to contribute to achievement of these targets.

To meet the GPRA requirements, SAMHSA must collect performance data from grantees. ATR grantees will be required to submit the performance data described below to SAMHSA. For the ATR program, SAMHSA will assess program performance through accountability measures as well as through client outcome measures. Grantees are required to submit to SAMHSA three types of data at varying points and frequencies: (1) GPRA data that collects information from clients at key points to measure changes in their outcomes, (2) voucher information which allows tracking of vouchers issued, and (3) voucher transactions which allow tracking of vouchers redeemed.

GPRA client data must be collected in a face-to-face interview at baseline (i.e., the client's entry into the project), six months post-baseline and at discharge (or exit from ATR services). Grantees are also expected to submit voucher information and voucher transaction data via the tools provided.

Grantees will be required to obtain an intake coverage rate (target number of clients expected to be served compared with actual number served) of 100% and a minimum 80% six-month follow-up rate. Note: The six-month follow-up rate calculation is calculated by dividing the number of follow-ups completed within the specified window by the number of intakes for which six months has elapsed. GPRA data must be entered into the GPRA Data Entry and Reporting System (https://www.samhsa-gpra.samhsa.gov)

within 7 business days of the interview forms (intake, six-month follow-up and discharge) or voucher information and transaction forms being completed. Grantees are expected to take action necessary to ensure data are valid and reliable, and are submitted in a timely manner. Data reporting is required to commence upon admission of the first client.

Accountability Measures

SAMHSA will assess grantee performance using the following accountability measures:[2]

- Target number of clients to be served (grantees are expected to meet 100% of their client target);
- Number of vouchers issued and redeemed;
- Number of eligible clinical treatment providers – total number of providers, providers identified as faith-based and providers identified as secular;
- Number of eligible recovery support service providers – total number of providers, providers identified as faith-based and providers identified as secular;
- Clinical treatment services – total clients served, clients served by faith-based organizations and clients served by secular organizations;
- Recovery support services – total clients served, clients served by faith-based organizations and clients served by secular organizations;
- Combined services – total clients served, clients served by faith-based organizations and clients served by secular organizations;
- Grant draw down amounts;
- Administrative expenditures;
- Expenditures for clinical treatment services – total expenditures, expenditures for services provided by faith-based organizations and expenditures for services provided by secular organizations;
- Expenditures for recovery support services – total expenditures, expenditures for services provided by faith-based organizations, and expenditures for services provided by secular organizations; and
- Combined expenditures for clinical treatment and recovery support services – total expenditures, expenditures for faith-based organizations, and expenditures for secular organizations.

Information should be provided on the type of service, date of service, and the days, partial days, or hour(s) of service provided. Each grantee should submit data on reimbursement rate per service (clinical treatment or recovery support service) per day, partial day, or hour(s) for the voucher program.

[2] Several performance measures will be reported for all providers, providers identified as faith-based and providers identified as secular. Grantees will receive training on how to provide this information using the provider identification number included in the Voucher Information Tool and Voucher Transaction Tool.

Outcome Measures

SAMHSA will assess outcomes for the ATR program through the National Outcome Measures (NOMs) for substance abuse treatment that SAMHSA has developed in partnership with the States. Grantees will be required to report performance in several areas relating to the client's substance use, family and living condition, employment status, social connectedness, access to treatment, retention in treatment and criminal justice status. Grantees must collect and report data using the Discretionary Services Client Level GPRA tool which can be found at http://www.samhsa-gpra.samhsa.gov (click on 'Data Collection Tools/Instructions'), along with instructions for completing it. All sections of this tool must be completed for each client served. Data on clients who screen negative should not be submitted to CSAT and will not count toward meeting client targets. There are two other tools grantees are responsible for using to collect and report data to CSAT: the voucher information tool and a voucher transaction tool, which can be found at http://www.samhsa-gpra.samhsa.gov (click on 'Data Collection Tools/Instructions' and select ATR Tools), along with instructions for completing it.

Grantees use the voucher information tool to report the amount for which the voucher was issued, and the voucher transaction tool is used to report the amount for which a specific provider redeemed the voucher. These two tools are used primarily for tracking the status of each voucher that is issued to an ATR client. It is important to note that these two tools are not asked of the client. It is the responsibility of program staff to report this programmatic information. Grantees can retain responsibility for transmitting data submitted by providers to SAMHSA. However, grantees (SSAs/Tribes/Tribal Organizations) can choose to allow providers to directly enter the required data.

Outcome data must be collected at the time of entry to and at exit from an episode of care and six months post entry. (For the purposes of the ATR program, an episode of care means the period of time from entry to exit from ATR-funded services, whether they are clinical treatment services or recovery support services.) Please note that the substance use domain is framed in terms of rates of frequency of use; however, the primary outcome measure for this program is abstinence from substance use.

Outcome data will be collected by individual service providers or SSA/provider designees and given to the grantees (i.e., SSAs/Tribes/Tribal Organizations). In a situation where a client is concurrently using multiple services, a single provider may be delegated the responsibility to collect data on client outcomes. Grantees (i.e., SSAs/Tribes/Tribal Organizations) will be responsible for transmitting the outcome data and other performance data to SAMHSA. Data will be submitted on an ongoing basis. As stated previously, grantees (SSAs/Tribes/Tribal Organizations) can retain responsibility for transmitting data submitted by providers to SAMHSA or they can choose to allow providers to submit the required data directly.

Applicants are strongly encouraged to review the required data collection forms at http://www.samhsa-gpra.samhsa.gov to determine what changes, if any, will be necessary to the data collection/management information systems within the SSA/Tribe/Tribal

Organization, so that these changes can be factored into the proposed project. For example, it will be necessary for SSAs/Tribes/Tribal Organizations to uniquely identify clients through the course of a clinical treatment/recovery support episode of care and provide basic demographic information. Client identifications (IDs) should be client specific and should also allow for clients to be tracked though multiple episodes of care.

The terms and conditions of the ATR grant award will include these data collection requirements. Grantees will be required to adhere to these terms and conditions. Grantee ability to demonstrate improvement in the above domains will be a factor in determining funding levels in years after year 1 of the grant.

2.2 Performance Assessment

Grantees must periodically review the performance data they report to SAMHSA (as required above) and assess their progress and use this information to improve management of their grant projects. The assessment should be designed to help determine whether the grantee is achieving the goals, objectives and outcomes intended to be achieved and whether adjustments need to be made to the project. Grantees will be required to report on their progress achieved, barriers encountered, and efforts to overcome these barriers in a performance assessment report to be submitted at least annually.

At a minimum, the performance assessment should include the required performance measures identified above. Grantees may also consider outcome and process questions, such as the following:

Outcome Questions:

- What approaches and strategies resulted in accomplishing key outcome goals?
- What program/contextual factors were associated with positive outcomes?
- Which combination of services yielded the best client outcomes and which resulted in poor client outcomes? Why?
- Were certain approaches or service combinations more or less effective with diverse populations (e.g., women, adolescents, racial and ethnic groups, etc)?
- How durable were the effects of positive outcomes?

Process Questions:

- How closely did implementation match the plan?
- What types of changes were made to the originally proposed plan?
- What led to the changes in the original plan?
- What effect did the changes have on the planned project and performance assessment?
- Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?

2.3 Grantee Meetings

Grantees must plan to send a minimum of four people (including the Project Director) to at least one joint grantee meeting in each year of the grant. Grantees must include a detailed budget and narrative for travel to this yearly grantee meeting in the proposed budget. At these meetings, grantees will present the results of their projects and Federal staff will provide technical assistance. Each meeting will be approximately 3 days. Yearly grantee meetings are usually held in the Washington, D.C., area and attendance is mandatory. In addition to these grantee meetings, grantee key staff and selected ATR providers may be required to attend additional meetings that focus on SAMHSA priorities as they relate to the ATR program. In these cases, SAMHSA will cover the expenses of travel for additional meetings (beyond the yearly grantee meeting), and attendance will be required.

II. AWARD INFORMATION

Funding Mechanism:	Grant
Anticipated Total Available Funding:	$95.5 million
Estimated Number of Awards:	30
Estimated Award Amount:	$2 million - $4 million
Length of Project Period:	Up to 4 years

Proposed budgets cannot exceed $4 million in total costs (direct and indirect) in any year of the proposed project. Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award. Awards may be adjusted based on the number of individuals proposed to be served per year.

Supplemental Awards Based on Performance: Section VI-2, Administrative and National Policy Requirements, of this RFA discusses a grantee's proposed performance targets and explains that failure to meet stated goals and objectives may result in suspension or termination of the grant award, or in the reduction or withholding of continuation awards. Conversely, an ATR grantee that exceeds its performance targets or demonstrates efficiencies may receive a supplemental award based on performance to maintain its high level of performance.

At the end of year 2 and year 3 of the ATR grant program, CSAT will review each grantee's cumulative GPRA data submissions to date and assess whether a grantee has:

1. Exceeded its target for the number of clients served by 25 percent or more;
2. Met or exceeded the 80% target for 6-month follow-up interviews; and

3. Provided services based on allowable and allocable cost principles.

(Note: The follow-up rate is calculated by dividing the number of follow-ups completed within the window by the number of intakes for which six months has elapsed.)

Any grantee that meets the above criteria when CSAT conducts the data reviews at the end of year 2 and year 3 may receive a supplemental award of up to 5 percent of the yearly requested amount. When the data is reviewed at the end of year 2, those grantees that meet the above criteria for years 1 and 2 will receive the supplemental award in year 3 of the grant. When the data is reviewed at the end of year 3, those grantees who meet the above criteria for years 1 through 3 will receive the supplemental award in year 4 of the grant. Grantees may be eligible to receive supplemental awards in both years 3 and 4 if the above criteria are met at the time CSAT conducts the data reviews.

Supplemental award amounts will be determined on a sliding scale based on availability of funds and the grantee's achievement of performance goals and demonstration of sound fiscal management. **Applicants should be aware that SAMHSA/CSAT does not plan to make supplemental awards to all grantees, and that it is possible that no grantees will receive supplemental awards based on performance.**

If grantees receive a supplemental award based on performance, they will be asked to submit a narrative and budget justification for the award amount. A grantee receiving a supplemental award based on performance may be subject to additional site visits and/or audits to verify the accuracy of the client data reported.

GRANTEE ADMINISTRATIVE COSTS

A list of services considered to be administrative costs is contained in **Appendix C-Items Included as Administrative Expenses** of this RFA. The direct and indirect costs of administration of the program are to include the management of information systems for tracking outcomes and costs, including the cost of data collection and reporting. These are to be held to as low a percentage of the total grant expenditures as possible. For all grantees, administrative costs are not to exceed 20% of the total grant expenditures over the four-year grant period. However, the percentage for the first year may exceed 20% to cover startup expenditures for such activities as establishing new voucher systems, provider networks, and State standards for recovery support services, as long as the 20% average is maintained over the life of the grant.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

Eligible applicants are the SSAs in the States, Territories, and the District of Columbia; and the highest ranking official and/or the duly authorized official of a federally recognized American Indian/Alaska Native Tribe or tribal organization. Tribal organization means the recognized body of any AI/AN Tribe; any legally established

organization of American Indians/Alaska Natives which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of American Indians/Alaska Natives in all phases of its activities. **The administrator of the SSA for Substance Abuse Services in the States, Territories, and the District of Columbia, or the highest ranking official and/or the duly authorized official of the Tribe or Tribal Organization must sign the application.** Following the initial award, the Administrator of the SSA or highest ranking official may not delegate responsibility for the grant to any other person or entity.

Eligibility is limited to these applicants because only they have the authority to coordinate funding across the State/Tribe, implement the necessary policy changes, manage the fiscal responsibilities, and coordinate the range of programs necessary for successful implementation of the voucher programs to be funded through these grants.

No more than one ATR application from any one SSA or head of a Tribe or Tribal Organization will be funded.

Current ATR grantees (those funded in 2007), as well as those funded in the 2004 ATR cohort, are eligible to apply for an ATR grant in 2010.

2. COST SHARING and MATCH REQUIREMENTS

Cost sharing/match are not required in this program.

3. OTHER

You must comply with the following requirements, or your application will be screened out and will not be reviewed: use of the PHS 5161-1 application form; application submission requirements in Section IV-3 of this document; and formatting requirements provided in **Appendix D** of this document.

IV. APPLICATION AND SUBMISSION INFORMATION

1. ADDRESS TO REQUEST APPLICATION PACKAGE

You may request a complete application kit from the SAMHSA Health Information Network at 1-877-SAMHSA7 [TDD: 1-800-487-4889].

You also may download the required documents from the SAMHSA Web site at http://www.samhsa.gov/grants/apply.aspx.

Additional materials available on this Web site include:

- a grant writing technical assistance manual for potential applicants;
- standard terms and conditions for SAMHSA grants;

- guidelines and policies that relate to SAMHSA grants (e.g., guidelines on cultural competence, consumer and family participation, and evaluation); and
- a list of certifications and assurances referenced in item 21 of the SF 424 v2.

2. CONTENT AND GRANT APPLICATION SUBMISSION

2.1 Application Kit

SAMHSA application kits include the following documents:

- PHS 5161-1 (revised July 2000) – Includes the face page (SF 424 v2), budget forms, assurances, certification, and checklist. You must use the PHS 5161-1. **Applications that are not submitted on the required application form will be screened out and will not be reviewed.**

- Request for Applications (RFA) – Provides a description of the program, specific information about the availability of funds, and instructions for completing the grant application. This document is the RFA. The RFA will be available on the SAMHSA Web site (http://www.samhsa.gov/grants/index.aspx) and a synopsis of the RFA is available on the Federal grants Web site (http://www.Grants.gov).

You must use all of the above documents in completing your application. A complete list of documents included in the application kit is available at http://www.samhsa.gov/Grants/ApplicationKit.aspx.

2.2 Required Application Components

Applications must include the required application components (Face Page, Abstract, Table of Contents, Budget Form, Project Narrative and Supporting Documentation, Attachments, Project/Performance Site Location(s) Form, Assurances, Certifications, Disclosure of Lobbying Activities, and Checklist).

- **Face Page** – SF 424 v2 is the face page. This form is part of the PHS 5161-1. [Note: Applicants must provide a Dun and Bradstreet (DUNS) number to apply for a grant or cooperative agreement from the Federal Government. SAMHSA applicants are required to provide their DUNS number on the face page of the application. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access the Dun and Bradstreet Web site at http://www.dunandbradstreet.com or call 1-866-705-5711. To expedite the process, let Dun and Bradstreet know that you are a public/private nonprofit organization getting ready to submit a Federal grant application.]

- **Abstract** – Your total abstract should not be longer than 35 lines. In the first sentence of your abstract, you must state whether you are a "New" or "Previously ATR-funded" applicant. It should include the project name, population to be served (demographics and clinical characteristics), strategies/interventions,

project goals and measurable objectives, including the number of people to be served annually and throughout the lifetime of the project, etc. In the first five lines or less of your abstract, write a summary of your project that can be used, if your project is funded, in publications, reporting to Congress, or press releases.

- **Table of Contents** – Include page numbers for each of the major sections of your application and for each attachment.

- **Budget Form** – Use SF 424A, which is part of the PHS 5161-1. Fill out Sections B, C, and E of the SF 424A. Additionally, you will be required to submit a detailed budget and narrative justification. The budget and narrative justification should include elements that clearly describe the major line items in the budget and demonstrate how figures were calculated. For example, if a line item in the budget is "Training Contract--$50,000", describe in the narrative justification how the $50,000 figure was derived (e.g., $5,000 for identifying training needs, $10,000 for delivering training in 3 regions, $2,000 supplies, etc.) An example of a budget table is included in **Appendix E** of this announcement. SAMHSA strongly recommends that applicants use the sample budget table as it has been specifically tailored to conform with the financial structure and expectations in the ATR program. Please note that your narrative justification must accompany the budget table.

- **Project Narrative and Supporting Documentation** – The Project Narrative describes your project. It consists of Sections A through D for new applicants and Sections A through E for previously ATR-funded applicants. These sections together may not be longer than 35 pages for new applicants, and 40 pages for previously ATR-funded applicants. (New applicants: Remember that if your Project Narrative starts on page 5 and ends on page 40, it is 36 pages long, not 35 pages; Previously ATR-funded applicants: Remember that if your Project Narrative starts on page 5 and ends on page 45, it is 41 pages long, not 40 pages.) More detailed instructions for completing each section of the Project Narrative are provided in "Section V – Application Review Information" of this document.

  The Supporting Documentation provides additional information necessary for the review of your application. This supporting documentation should be provided immediately following your Project Narrative in Sections F through I. There are no page limits for these sections, except for Section H, Biographical Sketches/Job Descriptions. Additional instructions for completing these sections are included in Section V under "Supporting Documentation." Supporting documentation should be submitted in black and white (no color).

- **Attachments 1 through 6** – Use only the attachments listed below. If your application includes any attachments not required in this document, they will be disregarded. Do not use more than a total of 30 pages for Attachments 3 and 4 combined. There are no page limitations for Attachments 1, 2, 5, and 6. Do not use attachments to extend or replace any of the sections of the Project Narrative.

Reviewers will not consider them if you do. Please label the attachments as: Attachment 1, Attachment 2, etc.

- *Attachment 1:* Letters of Commitment/Proposed Provider Directories, Memoranda of Understanding (signed or proposed)
- *Attachment 2:* Data Collection Instruments/Interview Protocols
- *Attachment 3:* Sample Consent Forms
- *Attachment 4:* Non-Supplantation Letter
- *Attachment 5:* Implementation Plan- Your implementation plan must include milestones that correspond with SAMHSA's stated implementation dates. At a minimum, the implementation plan must include the following milestones and activities with associated dates: at least 3 informational/orientation meetings with providers including community- and faith-based providers in each targeted region; development/enhancement of the voucher management system through full functionality; hiring/designation of all key staff; steps for establishing certification and beginning to upload GPRA data to the SAMHSA system; steps preceding the enrollment and servicing of clients.
- *Attachment 6 (If Applicable):* Past Performance Data (**For previously ATR-funded applicants only**)- Include, as Attachment 6 of your application, the letter sent to you from CSAT that presents your GPRA data from previous ATR grants. **Appendix N** contains the two tables that will be included in the letter that CSAT sends you. See **Appendix M** for more information regarding the evaluation of past ATR performance.

- **Project/Performance Site Location(s) Form** – This form is part of the PHS 5161-1. The purpose of this form is to collect location information on the site(s) where work funded under this grant announcement will be performed.

- **Assurances** – Non-Construction Programs. You must read the list of assurances provided on the SAMHSA Web site or in the application kit before signing the face page (SF 424 v2) of the application. You are also required to complete the Assurance of Compliance with SAMHSA Charitable Choice Statutes and Regulations Form SMA 170. This form will be posted on SAMHSA's Web site with the RFA and provided in the application kits.

- **Certifications** – You must read the list of certifications provided on the SAMHSA Web site or in the application kit before signing the face page (SF 424 v2) of the application.

- **Disclosure of Lobbying Activities** – You must submit Standard Form LLL found in the PHS 5161-1. Federal law prohibits the use of appropriated funds for publicity or propaganda purposes or for the preparation, distribution, or use of the information designed to support or defeat legislation pending before the Congress or State legislatures. This includes "grass roots" lobbying, which consists of appeals to members of the public suggesting that they contact their elected representatives to indicate their support for or opposition to pending legislation or

to urge those representatives to vote in a particular way. If no lobbying is to be disclosed, mark N/A on the form.

- **Checklist** – Use the Checklist found in PHS 5161-1. The Checklist ensures that you have obtained the proper signatures, assurances and certifications. If you are submitting a paper application, the Checklist should be the last page.

2.3 Application Formatting Requirements

Please refer to Appendix D, *Checklist for Formatting Requirements and Screenout Criteria for SAMHSA Grant Applications,* for SAMHSA's basic application formatting requirements. Applications that do not comply with these requirements will be screened out and will not be reviewed.

3. SUBMISSION DATES AND TIMES

Applications are due by close of business on **March 10, 2010.** Hard copy applications are due by 5:00 PM (Eastern Time). Electronic applications are due by 11:59 PM (Eastern Time). **Applications may be shipped using only Federal Express (FedEx), United Parcel Service (UPS), or the United States Postal Service (USPS).**

You will be notified by postal mail that your application has been received.

SAMHSA will not accept or consider any applications that are hand carried or sent by facsimile.

Your application must be received by the application deadline or it will not be considered for review. Please remember that mail sent to Federal facilities undergoes a security screening prior to delivery. You are responsible for ensuring that you submit your application so that it will arrive by the application due date and time.

If an application is mailed to a location or office (including room number) that is not designated for receipt of the application and, as a result, the designated office does not receive your application by the deadline, your application will be considered late and ineligible for review.

SAMHSA accepts electronic submission of applications through http://www.Grants.gov. Please refer to Appendix F for "Guidance for Electronic Submission of Applications." **If you plan to submit electronically through Grants.gov it is very important that you read thoroughly the application information provided in Appendix F, "Guidance for Electronic Submission of Applications."**

4. FUNDING LIMITATIONS/RESTRICTIONS

Cost principles describing allowable and unallowable expenditures for Federal grantees, including SAMHSA grantees, are provided in the following documents, which are available at http://www.samhsa.gov/grants/management.aspx:

- Institutions of Higher Education: OMB Circular A-21
- State and Local Governments and federally Recognized Indian Tribal Governments: OMB Circular A-87
- Nonprofit Organizations: OMB Circular A-122
- Hospitals: 45 CFR Part 74

SAMHSA's Access to Recovery grant recipients must comply with the funding restrictions detailed in **Appendix G** in addition to the following funding restrictions:

- Grant funds may not be used to supplant current funding for substance abuse clinical treatment and/or recovery support services.

- No more than 20% of the grant award may be used for administrative purposes for all ATR grantees. The 20% administrative cap is based on a four year average.

SAMHSA will not accept a "research" indirect cost rate. The grantee must use the "other sponsored program rate" or the lowest rate available.

5. OTHER SUBMISSION REQUIREMENTS

You may submit your application in either electronic or paper format:

Submission of Electronic Applications

SAMHSA accepts electronic submission of applications through http://www.Grants.gov. Electronic submission is voluntary. No review points will be added or deducted, regardless of whether you use the electronic or paper format.

To submit an application electronically, you must use the http://www.Grants.gov apply site. You will be able to download a copy of the application package from http://www.Grants.gov, complete it off-line, and then upload and submit the application via the Grants.gov site. E-mail submissions will not be accepted.

Please refer to Appendix F for detailed instructions on submitting your application electronically.

Submission of Paper Applications

You must submit an original application and 2 copies (including attachments). The original and copies must not be bound. Do not use staples, paper clips, or fasteners. Nothing should be attached, stapled, folded, or pasted.

Send applications to the address below:

For United States Postal Service:

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD **20857**

Change the zip code to **20850** if you are using another delivery service.

Do not send applications to other agency contacts, as this could delay receipt. Be sure to include "**ATR – TI-10-008**" and **"New"** or **"Previously ATR-funded"** in item number 12 on the face page (SF 424 v2) of any paper applications. If you require a phone number for delivery, you may use (240) 276-1199.

V. APPLICATION REVIEW INFORMATION

1. EVALUATION CRITERIA

The Project Narrative describes what you intend to do with your project and includes the Evaluation Criteria in Sections A-D for new applicants and Sections A-E for previously ATR-funded applicants below. Section E is specifically for previously ATR-funded applicants, and is a review of past performance with previous ATR grant(s); new applicants should simply state "Not Applicable" under Section E. Your application will be reviewed and scored according to the quality of your response to the requirements in these sections.

- In developing the Project Narrative section of your application, use these instructions, which have been tailored to this program. **These are to be used instead of the "Program Narrative" instructions found in the PHS 5161-1.**

- The Project Narrative (Sections A-D) together may be no longer than 35 pages for new applicants; the Project Narrative (Sections A-E) together for previously ATR-funded applicants may be no longer than 40 pages.

- You must use the sections/headings listed below in developing your Project Narrative. Be sure to place the required information in the correct section, **or it will not be considered.** Your application will be scored according to how well you address the requirements for each section of the Project Narrative.

- Reviewers will be looking for evidence of cultural competence in each section of the Project Narrative, and will consider how well you address the cultural competence aspects of the evaluation criteria when scoring your application. SAMHSA's guidelines for cultural competence can be found on the SAMHSA Web site at http://www.samhsa.gov/grants/apply.aspx at the bottom of the page under "Resources for Grant Writing." Additionally, due to the scope of the ATR program and the requirement to establish a large network of providers, evidence of cultural competence will include proactive measures to eliminate health disparities. Evidence of cultural competence will also include efforts to ensure cultural resonance—the appropriate application of cultural competence which reflects a true empathy and experience with the culture.

- The Supporting Documentation you provide in Sections F-I and Attachments 1-6 will be considered by reviewers in assessing your response, along with the material in the Project Narrative.

- The number of points after each heading is the maximum number of points a review committee may assign to that section of your Project Narrative. Although scoring weights are not assigned to individual bullets, each bullet is assessed in deriving the overall Section score.

Section A: Statement of Need (15 points)

New Applicants:

- Describe the current system for providing substance abuse clinical treatment and, if available, recovery support services in the proposed target area (i.e., the State, Territory or Tribe, or subsection of the State, Territory or Tribe). Include the number of clinical treatment and recovery support service providers currently funded by the State/Territory/Tribal Organization, gaps in service delivery, and barriers to service access.

- Describe the nature and prevalence of substance abuse problems in the target area. Quantify the need for services, capacity of the service system to provide services, and the difference between the two. Discuss how the focus of the target area and/or service gaps will meet identified needs and/or contribute toward the reduction of health disparities.

- Explicitly state whether or not the SSA/Tribe/Tribal Organization already has a voucher system in place to pay for substance abuse treatment and recovery support services. If so, discuss any enhancements that would be required to

implement the voucher program in proposed targeted areas. Explicitly state if no enhancements would be necessary.

Previously ATR-Funded Applicants:

- Describe the current system for providing substance abuse clinical treatment and, if available, recovery support services in the proposed target area (i.e., the State, Territory or Tribe, or subsection of the State, Territory or Tribe). Include the number of clinical treatment and recovery support service providers currently funded by the State/Territory/Tribal Organization, gaps in service delivery, and barriers to service access. Describe how the need for funding differs and/or focuses on issues beyond those targeted in previous ATR grants. Applicants must propose to enhance or expand efforts in the proposed geographic area, client population, services provided, or any other component that was not included in previous grant(s).

- Describe the nature and prevalence of substance abuse problems in the target area. Quantify the need for services, capacity of the service system to provide services, and the difference between the two. Discuss how the focus of the target area and/or service gaps will meet identified needs and/or contribute toward the reduction of health disparities. Include a description of how targeted areas build upon or expand areas of focus from previous ATR grants.

- Describe any enhancements to the existing electronic voucher management system that would need to be made in order to pay for substance abuse treatment and recovery support services in the proposed target areas. Explicitly state if no enhancements would be necessary.

Section B: Proposed Approach to Meet Program Goals
(40 points for new applicants; 30 points for previously ATR-funded applicants)

All applicants must address each item listed below in this section. In addition, previously ATR-funded applicants must include a description in each item of how you will build upon accomplishments and lessons learned from previous ATR grant(s).

- Clearly state the number of clients your project will serve by year for each of the four years of funding. [Please note, successful applicants may be asked to negotiate their clients served goals, in total and by year, to comport with the overall target SAMHSA must achieve—225,000 clients served over the total four years of the program.]

- Describe the project plans to ensure that yearly client target numbers are met and program funds are used as planned in the program budget. Specifically describe how data, including Federally mandated data, will be used to inform the management and quality improvement efforts of the program. Also, address

management practices, partnerships with community stakeholders and providers, and the use of the electronic voucher management system, as well as any other plans to ensure achievement of targets and appropriate use of funds.

- Describe plans for ensuring that Federally mandated data are collected at required intervals and uploaded to SAMHSA within the required timeframes. In the description, identify the entity(ies) that will be responsible for collecting data, especially the 6-month follow up data (e.g., providers, data collection team, contractors, etc.), and include a description of any incentives associated with 6-month follow-up data collection (either to clients [not to exceed $20] or to providers).

- Describe the approach that will be used to implement vouchers to pay for substance abuse treatment and recovery support services in the targeted implementation regions. In this section, include a clear description of each of the following:

    - Organizational/management structure (e.g., SSA/Tribe/Tribal Organization will manage all components of the project implementation, SSA/Tribe/Tribal Organization will award a contract to assist with implementing key parts of the project [e.g., 6-month GPRA follow-up interviews]).

    - Entities, institutions, or organizations that will refer clients into the ATR project for services (e.g., Drug Courts, Child Protective Services, Departments of Correction, community providers, etc.).

    - Development and implementation of the electronic voucher management system or enhancements needed to implement the electronic voucher management system if the applicant already has a voucher system in place.

    - Outreach and enrollment of community-based and faith-based organizations into the ATR network of providers to ensure genuine client choice including informational meetings and solicitation of these communities' input into the development of the proposal.

    - Eligibility criteria for provider organizations, including: (1) standards for all eligible provider organizations and/or processes to ensure individuals receive appropriate services in safe settings from appropriate individuals, including plans to enforce those standards and processes; and (2) reporting requirements. Describe how eligibility criteria will be tailored to include grassroots, faith- and community-based organizations. Provide assurances that eligibility criteria will not result in discrimination or exclusion of grassroots, faith- and community-based organizations. **(See Appendix H-Standards for the ATR Program)**.

- Describe the process to enable clinical treatment and recovery support services providers, including those previously unable to compete successfully for Federal funds, to participate in the voucher program (including faith-based and community-based providers). This process at a minimum should detail outreach efforts, enrollment efforts (including culturally and organizationally appropriate eligibility criteria), lines of communication (i.e., provider meetings, onsite visits, telephone, etc), and designation of liaisons between the SSA/Tribe/Tribal Organization and provider organizations to ensure ongoing collaboration. Clearly state how many of such clinical treatment and recovery support service providers are expected to be designated under this program. Affirm that faith-based organizations that otherwise satisfy program requirements will not be discriminated against on the basis of religious character or affiliation.

- Method/process for designating providers as eligible participants in the voucher program and for maintaining an up-to-date, client-friendly information service to ensure client choice is always available and clients are aware of their choices (e.g., a website or 24-hour staffed help line).

- Eligibility criteria for clients to receive vouchers for clinical treatment and recovery support services. If the proposed project has multiple populations of focus, clearly state the number of clients who would be successfully treated by referral source or population of focus under the proposed program.

- Policies and procedures for screening, assessment, level of care determinations, and the process for identifying available and appropriate clinical treatment and recovery support services options that will be offered to clients. The procedures should include a description of how client choice will be ensured. This section should also include a description of the process to ensure that clients receive a comprehensive assessment, using an instrument that assesses the need for clinical treatment and recovery support services **(See Appendix I for a discussion of clinical treatment and recovery support services, and Appendix J for information on screening, assessment, and level of care determination).**

- Process to ensure that clients receive vouchers for the most appropriate services and are transitioned between services based on established criteria **(See Appendices I and J for more information and resources about criteria)**. Include a description of care coordination or case management services to ensure that clients successfully enter clinical treatment and/or recovery support services following receipt of a voucher, regardless of where the client is seen for screening, assessment, and referral. Describe how these care coordination or case management services will contribute toward meeting identified needs and/or reducing health disparities.

- Provide evidence that voucher recipients will have a genuine, free, and independent choice among eligible clinical treatment and recovery support service options. Evidence is defined as having at least 2 providers available for each needed service, one of which should be a provider to which the client has no religious objection.

- Method/process for measuring client satisfaction in management of the voucher program.

- Submit as **Attachment 5** of your application, a four-year plan for implementing the project. The plan must include specific milestones with target dates for their achievement and must identify the party(ies) responsible for achieving milestones. **(Appendix K of the RFA provides a model template for implementation planning.)**

Section C: Readiness to Implement/Expand (25 points for new applicants; 20 points for previously ATR-funded applicants)

New Applicants—Readiness to Implement

Describe your ability to fully implement the project within four months after the award date. Implementation includes the following:

- A fully functioning electronic voucher management system capable of issuing and tracking vouchers.
- An enrolled and trained network of both clinical treatment and recovery support service providers, including faith-based organizations capable of serving ATR clients. (Based on ATR I and II data, approximately 47% of all providers redeeming vouchers were recovery support service providers, and approximately 35% of all providers redeeming vouchers were faith-based organizations.)
- Enrolling and serving clients.
- Uploading Federally mandated GPRA data at required intervals and within required timelines.
- Submission to SAMHSA Government Project Officer (GPO) signed Memoranda of Understanding (MOU) if SSA/Tribe/Tribal Organization is proposing to establish referrals from major institutional systems (Drug Courts, Department of Corrections, Child Protective Services, etc.) into ATR. One MOU should be established with each institutional system and should include specific details about referral pathways, how the two systems will partner, and potential number of referrals into ATR services. See **Appendix L** for a sample MOU.

- Document which of the following capabilities the SSA/Tribe/Tribal Organization **currently possesses** to implement the voucher system:

- Ability to make eligibility determinations for clients and providers.
- Ability to manage and monitor a voucher program.
- Ability to set reimbursement rates and monitor costs per person served.
- Ability to collect and report data (either through an existing or planned system).
- Ability to implement quality improvement activities including technical assistance and training.
- Ability to establish and implement standards for clinical treatment and/or recovery support service providers.
- Capability to conduct screening and assessment and issue vouchers for clinical treatment and recovery support services based on established criteria.
- Capability to provide a list of eligible providers for anyone to whom a voucher is issued.

- Describe anticipated potential operational problems, if any, and propose feasible solutions to them, including seeking technical assistance from SAMHSA. Examples include:

  - Establishing referral pathways from major institutional systems into ATR services such as Drug Courts, Departments of Correction, or Child Protective Services Agencies.
  - Ensuring clients genuine, free, and independent choice of clinical treatment and/or recovery support providers in situations in which the range and number of providers are limited.
  - Handling significant numbers of clients eligible for vouchers who may exceed the State's ability to fund vouchers, and ensuring that resources are appropriately allocated during the course of the year.
  - Preventing potential conflict-of-interest among those conducting screening, assessment, level of care determination, and service provision.

- Describe other organizations/entities partnering in the project, including their roles in implementing the voucher program. In Attachment 1 of the application, provide letters of commitment, directories of providers, and potential or signed MOUs showing that identified partner organizations are not only committed but are *ready* and able to fulfill their roles. For example, to demonstrate the readiness of community-based and faith-based organizations to participate in ATR, include, with their consent, a directory of potential faith-based and community-based service providers, including their names and proposed services. For partnerships with major institutional systems (Department of Corrections, Child Protective Services, Drug Courts, etc.), include a MOU that may be signed or negotiated after award or, if possible, a signed MOU to define the referral process that would ultimately create a pathway from the institutional facility into ATR services. Each MOU should delineate roles, responsibilities, and indicate numbers of referrals.

Previously ATR-funded applicants—Readiness to Expand

- Describe your ability to fully implement the project within three months after the award date. Implementation includes the following:
    - A fully functioning electronic voucher management system capable of issuing and tracking vouchers.
    - An enrolled and trained network of both clinical treatment and recovery support service providers including faith-based organizations capable of serving ATR clients. (Based on ATR I and II data, approximately 47% of all providers redeeming vouchers were recovery support service providers, and approximately 35% of all providers redeeming vouchers were faith-based organizations.)
    - Enrolling and serving clients.
    - Uploading Federally mandated GPRA data at required intervals and within required timelines.
    - Submission to SAMHSA Government Project Officer (GPO) signed Memoranda of Understanding (MOU) if SSA/Tribe/Tribal Organization is proposing to establish referrals from major institutional systems (Drug Courts, Department of Corrections, Child Protective Services, etc.) into ATR. One MOU should be established with each institutional system and should include specific details about referral pathways, how the two systems will partner, and potential number of referrals into ATR services. See **Appendix L** for a sample MOU.

- Document which of the following capabilities the SSA/Tribe/Tribal Organization **currently possesses** to implement the voucher system. Highlight how you will build upon and expand these capabilities from your previous ATR grant(s):

    - Ability to make eligibility determinations for clients and providers.
    - Ability to manage and monitor a voucher program.
    - Ability to set reimbursement rates and monitor costs per person served.
    - Ability to collect and report data (either through an existing or planned system).
    - Ability to implement quality improvement activities including technical assistance and training.
    - Ability to establish and implement standards for clinical treatment and/or recovery support service providers.
    - Capability to conduct screening and assessment and issue vouchers for clinical treatment and recovery support services based on established criteria.
    - Capability to provide a list of eligible providers for anyone to whom a voucher is issued.

- Describe anticipated potential operational problems, if any, and propose feasible solutions to them, including seeking technical assistance from SAMHSA. Highlight how you will rely on lessons learned from previous ATR grant(s) and build upon accomplishments from previous ATR grant(s). Examples include:

- Establishing referral pathways from major institutional systems into ATR services such as Drug Courts, Departments of Correction, or Child Protective Services agencies.
- Ensuring clients genuine, free, and independent choice of clinical treatment and/or recovery support providers in situations in which the range and number of providers are limited.
- Handling significant numbers of clients eligible for vouchers who may exceed the State's ability to fund vouchers, and ensuring that resources are appropriately allocated during the course of the year.
- Preventing potential conflict-of-interest among those conducting screening, assessment, level of care determination, and service provision.

- Describe other organizations/entities partnering in the project, including their roles in implementing the voucher program. In Attachment 1 of the application, provide letters of commitment, directories of providers, and potential or signed MOUs showing that identified partner organizations are not only committed but are *ready* and able to fulfill their roles. For example, to demonstrate the readiness of community-based and faith-based organizations to participate in ATR, include, with their consent, a directory of potential faith-based and community-based service providers, including their names and proposed services. For partnerships with major institutional systems (Department of Corrections, Child Protective Services, Drug Courts, etc), include a MOU that may be signed or negotiated after award or, if possible, a signed MOU to define the referral process that would ultimately create a pathway from the institutional facility into ATR services. Each MOU should delineate roles, responsibilities, and indicate numbers of referrals.

new county?

Section D: Management, Staffing and Cost Controls (20 points)

New Applicants

- Describe how the lead agency will manage the voucher program, including steps that will be taken to ensure quality of care; prevent waste, fraud and abuse; and prevent supplantation of funds.

- Describe the resources available for the project. Document that resources will be appropriately allocated throughout the project period to ensure against funding shortfalls.

- Describe how the lead agency will work with other agencies with roles and responsibilities related to identifying clients and implementing and administering the voucher program.

- Describe how the provider performance issues will be addressed through the process of determining provider eligibility and through monitoring/oversight.

- Describe the SSA's/Tribes'/Tribal Organizations' and other participating entities' experience managing other voucher-type programs (e.g., Temporary Assistance for Needy Families [TANF], HUD/housing, daycare), if any, and discuss how these experiences will be applied to the proposed voucher program.

- Describe qualifications of the key staff, including the Project Director, Treatment and Recovery Support Services Coordinator, Information Technology Coordinator, and Fiscal Coordinator, to effectively implement and manage the proposed project.

- Document the ability or present a plan for developing the ability of the SSA/Territory/Tribal Organization to collect and report all necessary GPRA data, including data on costs and outcomes, to SAMHSA.

- Describe the process the SSA/Tribe/Tribal Organization will use to regularly monitor implementation of the voucher program (including costs and outcomes) and make adjustments to the program (including the introduction of evidence-based practices) in order to achieve the intended outcomes in the most cost-effective manner. Specify how the SSA/Tribe/Tribal Organization will create incentives for positive outcomes (e.g., adjusting provider eligibility reimbursement based on such outcomes). The extent to which evidence supports abstinence from substance use is of the utmost importance in assessing provider performance.

- Describe the process for establishing reimbursement rates for services provided through vouchers.

- Describe how the SSA/Tribe/Tribal Organization will manage the program using a proactive effort to meet identified needs and/or reduce health disparities.

- Describe how the SSA/Tribe/Tribal Organization will manage the program on the basis of reasonable costs. Include a justification if the applicant proposes to deviate from the cost ranges outlined in **Appendix M.**

NOTE: Although the budget for the proposed project is not a scored review criterion, the Review Group will be asked to comment on the appropriateness of the budget after the merits of the application have been considered.

Previously ATR-funded applicants

- Describe how the lead agency will manage the voucher program, including steps that will be taken to ensure quality of care; prevent waste, fraud and abuse; and prevent supplantation of funds build upon accomplishments and lessons learned from previous ATR grant(s).

- Describe the resources available for the project. Document that resources will be appropriately allocated throughout the project period to ensure against funding shortfalls. Describe how proposed resource management will build upon accomplishment and lessons learned from previous ATR grant(s).

- Describe how the lead agency will work with other agencies with roles and responsibilities related to identifying clients and implementing and administering the voucher program. Describe how these partnerships will build upon accomplishments and lessons learned from previous ATR grant(s).

- Describe how the provider performance issues will be addressed through the process of determining provider eligibility and through monitoring/oversight. Describe how provider monitoring and oversight will build upon accomplishments and lessons learned from previous ATR grant(s).

- Describe the SSA's/Tribe/Tribal Organization's previous experience with managing an ATR grant and any other voucher type program. Discuss how these experiences will be applied to the proposed voucher program with a special focus on lessons learned.

- Describe qualifications of the key staff, including the Project Director, Treatment and Recovery Support Services Coordinator, Information Technology Coordinator, and Fiscal Coordinator, to effectively implement and manage the proposed project including experience with previous ATR grant(s).

- Document the ability or present a plan for developing the ability of the SSA/Territory/Tribal Organization to collect and report all necessary GPRA data, including data on costs and outcomes, to SAMHSA. Discuss how these reporting abilities build upon accomplishments or lessons learned from previous ATR grant(s).

- Describe the process the SSA/Tribe/Tribal Organization will use to regularly monitor implementation of the voucher program (including costs and outcomes) and make adjustments to the program (including the introduction of evidence-based practices) in order to achieve the intended outcomes in the most cost-effective manner. Specify how the SSA/Tribe/Tribal Organization will create incentives for positive outcomes (e.g., adjusting provider eligibility reimbursement based on such outcomes). The extent to which evidence supports abstinence from substance use is of the utmost importance in assessing provider performance. Discuss how you will build upon accomplishments and lessons learned from previous ATR grant(s).

- Describe the process for establishing or refining reimbursement rates for services provided through vouchers. Discuss how you will build upon accomplishments and lessons learned from previous ATR grant(s).

- Describe how the SSA/Tribe/Tribal Organization will manage the program using a proactive effort to meet identified needs and/or reduce health disparities.

- Discuss how the proposed project will achieve improved efficiencies over the course of the project.

- Describe how the SSA/Tribe/Tribal Organization will manage the program on the basis of reasonable costs. Include a justification if the applicant proposes to deviate from the cost ranges outlined in **Appendix M**.

NOTE: Although the budget for the proposed project is not a scored review criterion, the Review Group will be asked to comment on the appropriateness of the budget after the merits of the application have been considered.

Section E: Past Performance with ATR grant(s)—Previously ATR-funded applicants only (15 Points):

NOTE: New Applicants should simply state "Not Applicable" for Section E.

For this section, application reviewers will evaluate two past performance measures based on previous ATR GPRA data: achievement of clients served targets and use of funds as planned in the program budget (See Section I-2- Past Performance Evaluation of Previously ATR-Funded Applicants). Application reviewers will assign points according to the scoring sheet provided in **Appendix N** of this RFA. The scoring sheet is structured to evaluate performance by year for a total of fifteen available points.

As Attachment 6 of your application, submit the letter you will receive from CSAT which includes the above referenced past ATR performance data. CSAT will send the letters within three business weeks of the announcement of this RFA. No additional submissions or narratives are required for Section E other than Attachment 6.

SUPPORTING DOCUMENTATION

Section F: Literature Citations. This section must contain complete citations, including titles and all authors, for any literature you cite in your application.

Section G: Budget and Narrative Justification, Existing Resources, Other Support. You must provide a budget and narrative justification of the items included in your proposed budget, as well as a description of existing resources and other support you expect to receive for the proposed project. Be sure to show that no more than 20% of the total grant award will be used for administrative costs. The sample budget table is included in **Appendix E** of this document.

- You must identify administrative expenses and justify the percent of the budget that will be allocated to administrative expenses.

- You should justify your proposed budget on the basis of a variety of factors, including specification of the direct and indirect costs of the project and the relationship of those costs to the number of people to be served, the number of vouchers to be issued, the size and complexity of the service delivery system to be converted to a voucher program, and the nature of the barriers which must be addressed in order to successfully implement a voucher program.

- You should be mindful of the need to demonstrate that the proposed project will implement the most cost effective mix of clinical treatment and recovery support services necessary to achieve the intended outcomes of the project.

Section H: Biographical Sketches and Job Descriptions.

- Include a biographical sketch for the Project Director and other key positions. Each sketch should be 2 pages or less. If the person has not been hired, include a position description and/or a letter of commitment with a current biographical sketch from the individual.
- Include job descriptions for key personnel. Job descriptions should be no longer than 1 page each.
- Information on what should be included in biographical sketches and job descriptions can be found on page 22, Item 6, in the Program Narrative section of the PHS 5161-1 instruction page, available on the SAMHSA Web site.

Section I: Confidentiality and SAMHSA Participant Protection/Human Subjects: You must describe procedures relating to Confidentiality, Participant Protection and the Protection of Human Subjects Regulations in Section I of your application, using the guidelines provided below.

Confidentiality and Participant Protection:

Because of the confidential nature of the work in which many SAMHSA grantees are involved, it is important to have safeguards protecting individuals from risks associated with their participation in SAMHSA projects. All applicants must address the seven elements below. If some are not applicable or relevant to the proposed project, simply state that they are not applicable and indicate why. In addition to addressing these seven elements, read the section that follows entitled Protection of Human Subjects Regulations to determine if the regulations may apply to your project. If so, you are required to describe the process you will follow for obtaining Institutional Review Board (IRB) approval. While we encourage you to keep your responses brief, there are no page limits for this section and no points will be assigned by the Review Committee. Problems with confidentiality, participant protection, and the protection of human subjects identified during peer review of the application must be resolved prior to funding.

1. Protect Clients and Staff from Potential Risks

   - Identify and describe any foreseeable physical, medical, psychological, social, and legal risks or potential adverse effects as a result of the project itself or any data collection activity.

   - Describe the procedures you will follow to minimize or protect participants against potential risks, **including risks to confidentiality**.

   - Identify plans to provide guidance and assistance in the event there are adverse effects to participants.

   - Where appropriate, describe alternative treatments and procedures that may be beneficial to the participants. If you choose not to use these other beneficial treatments, provide the reasons for not using them.

2. Fair Selection of Participants

   - Describe the population(s) of focus for the proposed project. Include age, gender, and racial/ethnic background and note if the population includes homeless youth, foster children, children of substance abusers, pregnant women, or other targeted groups.

   - Explain the reasons for including groups of pregnant women, children, people with mental disabilities, people in institutions, prisoners, and individuals who are likely to be particularly vulnerable to HIV/AIDS.

   - Explain the reasons for including or excluding participants.

   - Explain how you will recruit and select participants. Identify who will select participants.

3. Absence of Coercion

   - Explain if participation in the project is voluntary or required. Identify possible reasons why participation is required, for example, court orders requiring people to participate in a program.

   - If you plan to compensate participants, state how participants will be awarded incentives (e.g., money, gifts, etc.). Provide justification that the use of incentives is appropriate, judicious, and conservative and that incentives do not provide an "undue inducement" which removes the voluntary nature of participation. Incentives should be the minimum amount necessary to meet the programmatic and performance assessment goals of the grant. Applicants should determine the minimum amount that is proven effective by consulting with existing local

programs and reviewing the relevant literature. In no case may the value if an incentive paid for with SAMHSA discretionary grant funds exceed $20.

- State how volunteer participants will be told that they may receive services intervention even if they do not participate in or complete the data collection component of the project.

4. Data Collection

   - Identify from whom you will collect data (e.g., from participants themselves, family members, teachers, others). Describe the data collection procedures and specify the sources for obtaining data (e.g., school records, interviews, psychological assessments, questionnaires, observation, or other sources). Where data are to be collected through observational techniques, questionnaires, interviews, or other direct means, describe the data collection setting.

   - Identify what type of specimens (e.g., urine, blood) will be used, if any. State if the material will be used just for evaluation or if other use(s) will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

   - Provide in **Attachment 2, "Data Collection Instruments/Interview Protocols,"** copies of all available data collection instruments and interview protocols that you plan to use.

5. Privacy and Confidentiality

   - Explain how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.

   - Describe:

     - How you will use data collection instruments.
     - Where data will be stored.
     - Who will or will not have access to information.
     - How the identity of participants will be kept private, for example, through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

NOTE: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records according to the provisions of **Title 42 of the Code of Federal Regulations, Part II.**

6. Adequate Consent Procedures

- List what information will be given to people who participate in the project. Include the type and purpose of their participation. Identify the data that will be collected, how the data will be used and how you will keep the data private.

- State:

  - Whether or not their participation is voluntary.
  - Their right to leave the project at any time without problems.
  - Possible risks from participation in the project.
  - Plans to protect clients from these risks.

- Explain how you will get consent for youth, the elderly, people with limited reading skills, and people who do not use English as their first language.

NOTE: If the project poses potential physical, medical, psychological, legal, social or other risks, you **must** obtain written informed consent.

- Indicate if you will obtain informed consent from participants or assent from minors along with consent from their parents or legal guardians. Describe how the consent will be documented. For example: Will you read the consent forms? Will you ask prospective participants questions to be sure they understand the forms? Will you give them copies of what they sign?

- Include, as appropriate, sample consent forms that provide for: (1) informed consent for participation in service intervention; (2) informed consent for participation in the data collection component of the project; and (3) informed consent for the exchange (releasing or requesting) of confidential information. The sample forms must be included in **Attachment 3, "Sample Consent Forms"**, of your application. If needed, give English translations.

NOTE: Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or releases your project or its agents from liability for negligence.

- Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both participant protection in treatment intervention and for the collection and use of data?

- Additionally, if other consents (e.g., consents to release information to others or gather information from others) will be used in your project, provide a description of the consents. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

7. Risk/Benefit Discussion

- Discuss why the risks are reasonable compared to expected benefits and importance of the knowledge from the project.

Protection of Human Subjects Regulations

SAMHSA expects that most grantees funded under this announcement will not have to comply with the Protection of Human Subjects Regulations (45 CFR 46), which requires Institutional Review Board (IRB) approval. However, in some instances, the applicant's proposed performance assessment design may meet the regulation's criteria for research involving human subjects. For assistance in determining if your proposed performance assessment meets the criteria in 45 CFR 46, Protection of Human Subjects Regulations, refer to the SAMHSA decision tree on the SAMHSA Web site, under "Applying for a New SAMHSA Grant," http://www.samhsa.gov/grants/apply.aspx.

In addition to the elements above, applicants whose projects must comply with the Human Subjects Regulations must fully describe the process for obtaining IRB approval. While IRB approval is not required at the time of grant award, these grantees will be required, as a condition of award, to provide documentation that an Assurance of Compliance is on file with the Office for Human Research Protections (OHRP). IRB approval must be received in these cases prior to enrolling participants in the project. General information about Human Subjects Regulations can be obtained through OHRP at http://www.hhs.gov/ohrp, or ohrp@osophs.dhhs.gov, or (240) 453-6900. SAMHSA–specific questions should be directed to the program contact listed in Section VII of this announcement.

2. REVIEW AND SELECTION PROCESS

SAMHSA applications are peer-reviewed according to the evaluation criteria listed above. For those programs where the individual award is over $100,000, applications also must be reviewed by the appropriate National Advisory Council.

Decisions to fund a grant are based on:

- the strengths and weaknesses of the application as identified by peer reviewers and, when applicable, approved by the Center for Substance Abuse Treatment's National Advisory Council;

- availability of funds;

- equitable distribution of awards in terms of geography (including urban, rural and remote settings) and balance among populations of focus and program size; and

- past performance (for previously ATR-funded applicants only).

VI. ADMINISTRATION INFORMATION

1. AWARD NOTICES

After your application has been reviewed, you will receive a letter from SAMHSA through postal mail that describes the general results of the review, including the score that your application received.

If you are approved for funding, you will receive an **additional** notice through postal mail, the Notice of Award (NoA), signed by SAMHSA's Grants Management Officer. The Notice of Award is the sole obligating document that allows you to receive Federal funding for work on the grant project.

If you are not funded, you may re-apply if there is another receipt date for the program.

2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

- If your application is funded, you must comply with all terms and conditions of the grant award. SAMHSA's standard terms and conditions are available on the SAMHSA Web site at http://www.samhsa.gov/grants/management.aspx.

- If your application is funded, you must also comply with the administrative requirements outlined in 45 CFR Part 74 or 45 CFR Part 92, as appropriate. For more information see the SAMHSA Web site (http://www.samhsa.gov/grants/management.aspx).

- Depending on the nature of the specific funding opportunity and/or your proposed project as identified during review, SAMHSA may negotiate additional terms and conditions with you prior to grant award. These may include, for example:
  - actions required to be in compliance with confidentiality and participant protection/human subjects requirements;
  - requirements relating to additional data collection and reporting;
  - requirements relating to participation in a cross-site evaluation;
  - requirements to address problems identified in review of the application; or
  - revised budget and narrative justification.

- If your application is funded, you will be held accountable for the information provided in the application relating to performance targets. SAMHSA program officials will consider your progress in meeting goals and objectives, as well as your failures and strategies for overcoming them, when making an annual recommendation to continue the grant and the amount of any continuation award. Failure to meet stated goals and objectives may result in suspension or termination of the grant award, or in reduction or withholding of continuation awards.

- Grant funds cannot be used to supplant current funding of existing activities. "Supplant" is defined as replacing funding of a recipient's existing program with funds from a Federal grant.

- In an effort to improve access to funding opportunities for applicants, SAMHSA is participating in the U.S. Department of Health and Human Services "Survey on Ensuring Equal Opportunity for Applicants." This survey is included in the application kit for SAMHSA grants and is posted on the SAMHSA Web site at http://www.samhsa.gov/grants/downloads/SurveyEnsuringEqualOpp.pdf. You are encouraged to complete the survey and return it, using the instructions provided on the survey form.

3. REPORTING REQUIREMENTS

In addition to the data reporting requirements listed in Section I-2.1, you must comply with the following reporting requirements:

3.1 Progress and Financial Reports

- You will be required to submit monthly and quarterly progress reports, annual financial status reports, one final program report, and one final financial status report. This reporting is in addition to the GPRA data which must be submitted on an ongoing basis.

- The monthly progress reports must include the performance data described in Section I-2.1 of this announcement, as well as information about fraud and abuse monitoring and examples of client success, until the grantee develops the capability to upload data through CSAT's GPRA Data Entry and Reporting System (www.samhsa-gpra.samhsa.gov). After that time, the monthly progress reports will include only the performance information not captured in the GPRA Data Entry and Reporting System (e.g., information about fraud and abuse monitoring and examples of client success).

- Because SAMHSA is extremely interested in ensuring that treatment and prevention services can be sustained, your progress reports should explain plans to ensure the sustainability of efforts initiated under this grant.

- If your application is funded, SAMHSA will provide you with guidelines and requirements for these reports at the time of award and at the initial grantee orientation meeting after award. SAMHSA staff will use the information contained in the reports to determine your progress toward meeting its goals.

3.2 Government Performance and Results Act (GPRA)

The Government Performance and Results Act (GPRA) mandates accountability and performance-based management by Federal agencies. To meet the GPRA requirements, SAMHSA must collect performance data (i.e., "GPRA data") from grantees. The performance requirements for SAMHSA's ATR grant program are described in Section I-2.1 of this document under "Data Collection and Performance Measurement."

3.3 Publications

If you are funded under this grant program, you are required to notify the Government Project Officer (GPO) and SAMHSA's Publications Clearance Officer (240-276-2130) of any materials based on the SAMHSA-funded grant project that are accepted for publication.

In addition, SAMHSA requests that grantees:

- Provide the GPO and SAMHSA Publications Clearance Officer with advance copies of publications.

- Include acknowledgment of the SAMHSA grant program as the source of funding for the project.

- Include a disclaimer stating that the views and opinions contained in the publication do not necessarily reflect those of SAMHSA or the U.S. Department of Health and Human Services, and should not be construed as such.

SAMHSA reserves the right to issue a press release about any publication deemed by SAMHSA to contain information of program or policy significance to the substance abuse treatment/substance abuse prevention/mental health services community.

VII. AGENCY CONTACTS

For questions about program issues contact:

Roula K. Sweis, MA, PsyD
Division of Services Improvement, Center for Substance Abuse Treatment
1 Choke Cherry Road
Room 5-1101
Rockville, MD 20857
(240) 276-1574
roula.sweis@samhsa.hhs.gov

For questions on grants management and budget issues contact:

William Reyes
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Room 7-1095
Rockville, Maryland 20857
(240) 276-1406
william.reyes@samhsa.hhs.gov

Appendix A – Examples of How an SSA/Tribal Organization Could Implement a Voucher Program

Following are two examples of how an ATR grantee could use vouchers for assessment and level of care determination, as well as for substance use clinical treatment and/or recovery support services. Applicants should be innovative in their approaches.

Please note that technical assistance is available to all applicants to assist them in the development and implementation processes. We encourage all applicants to seek such assistance.

Example 1: State of West Riverton

Grant Award Date: August, 2010
Implementation Date: December, 2010
Client Target for Year 1: 1,117
Client Target for Year 2: 2,358
Client Target for Year 3: 2,358
Client Target for Year 4: 1,667

Area of Focus: Middle and Southern Regions (25 counties)

Populations of Focus: The State of West Riverton Access to Recovery (ATR) initiative will focus on delivering services geared toward the following high-risk, underserved populations:

1. Substance abusing adolescents and young adults.
2. Low income individuals in crisis who are involved with child protective services, shelters and medical clinics as a result of drug dependence and abuse. Special emphasis and outreach is being placed on adult women.
3. Adults 18 and over who are involved with the criminal justice system/drug courts or those who are exiting the correctional system.

Outreach to Providers: West Riverton recognized it had to set a minimum level of eligibility criteria and standards for each provider within the clinical treatment and recovery support services network to provide quality treatment services to its citizens. All clinical treatment organizations must meet existing State licensing and certification standards for clinical treatment and assessment. For recovery support services not currently offered through West Riverton's State Department of Drug and Alcohol Substance Abuse Services (WRSDASAS), ATR recovery specialists refer clients to recovery support service providers who meet grantee-established eligibility standards. Therefore, in accordance with State administrative procedures, West Riverton published eligibility criteria and standards and created a list of eligible entities to provide assessment and level of care determination, as well as clinical treatment and recovery support services. West Riverton makes diligent efforts to conduct outreach and

marketing to providers previously unable to compete for Federal funds, including faith-based and community organizations. West Riverton uses educational meetings to introduce the concept of ATR, provide enrollment information, and to give information about the recovery support services ATR vouchers will support. Enrollment meetings are utilized to enroll recovery support providers, to distribute the eligibility requirements for participation, and to offer help to providers for attaining the eligibility standards required for ATR participation. To aid with community outreach, the SSA designated a faith-based liaison to focus on outreach and engagement with the faith-based providers and other providers that may not have a history of working with the SSA. This liaison regularly meets with faith- and community-based providers, explains ATR processes, and identifies ways to strengthen the ATR collaboration with a special focus on sustainability. The SSA also requests technical assistance from SAMHSA to support outreach and enrollment of providers, with a focus on community- and faith-based organizations and customized outreach to recovery support services providers that offer peer-to-peer services.

Any provider interested in being part of the voucher program will be required to participate in a training program. Once a provider has completed the training, it will be enrolled officially in the ATR voucher program and the provider name and faith-based affiliation, if any, are added to the resource listing through the Helpline. The list of new providers is shared with county coordinators. At the outset of their voucher initiative, West Riverton developed an eligibility application process and incentives to improve outcomes. As part of the application process, providers agreed to receive 90% of the reimbursement rate for their services; 10% was withheld and set aside to be used to reimburse and encourage positive client outcomes.

Fifty (50) new clinical treatment providers met the licensing and certification criteria already established by the SSA. When West Riverton implemented the ATR program, 28 recovery support providers, including 13 faith-based organizations, had been identified, met the eligibility criteria, and agreed to the reimbursement rates established by West Riverton. The recovery support service providers agreed to the grantee established definitions of recovery support services and the reimbursement rates for these services (developed by the SSA). All of the aforementioned providers signed Memoranda of Understanding to provide ATR services should they be selected by a client. All received at least one GPRA training session. Outreach/recruitment activities and training are ongoing. Non-traditional providers unable to meet standards will receive technical assistance and training to help them meet the requirements. Faith-based programs that have the ability to provide clinical treatment services will receive assistance for achieving licensure. The West Riverton Faith-Based Association (FBA) will have responsibility for certifying unlicensed faith-based organizations that wish to provide recovery support services.

Outreach to Clients: West Riverton proposed to expand its current addiction programs by offering voucher driven alcohol and drug treatment/recovery support services in select regions. The scheduled implementation date was November 1, 2010.

West Riverton established a 24-hour, 7-day-a-week telephone line for their ATR project (800-FOR-HELP). This number made available a list of eligible assessment, treatment, and recovery support service providers (throughout the implementation region) for the voucher treatment system. West Riverton is committed to providing an administrative process which ensures individuals receive appropriate services in safe settings and services delivered by appropriate individuals. When the program opened it doors as scheduled, the 800 telephone number had been activated. This number, the West Riverton ATR website, and a major media kick-off blitz, gave the public direct and ready access to the multiple portals of entry for both potential clients and ongoing recruitment of potential caregivers. Potential clients are also able to do a brief screening and self assessment via the telephone or online. Initial appointments can be made by telephone or sent electronically. Referrals to the ATR are provided by partners at various sites, such as the public assistance/ child welfare offices, the juvenile and adult courts, the prison and jail sites and medical hospitals and clinics.

Additionally, all key staff were in place and all Helpline call center employees had attended thorough ATR customer service orientation and training on dealing with difficult/suicidal clients.

How vouchers are issued: A critical component of West Riverton's voucher program is its Electronic Information System (EIS). As clients submit a *request for services*, the enrolling provider enters the client into the electronic voucher system. A first task is to establish a client's identity and ascertain whether she or he had previously participated in the voucher program. If a client is new to the voucher system, they receive a *unique client number* and an initial client record is created. Initial contact information includes, at a minimum, name, social security number, birth date, and – where possible – substance use problem information. When the vouchers are issued (electronically) the client acknowledges by signature that he/she invoked their right to select from a list of providers appropriate to meet their assessed treatment/recovery support needs. The intake/assessment staff does a telephone follow up after 72 hours to ascertain whether or not the client kept the appointment. A bi-monthly call is made to the facility/organization to confirm the client is still in attendance. Any client who does not present for services is terminated from the ATR rolls after 60 days of non-activity. To re-enroll, a client must repeat the intake and assessment process. Separate vouchers are issued for each type of service. Vouchers have no cash value.

The SSA of West Riverton specifies that payments to providers be calculated on a service-by-service basis (unbundled), using a standardized rate schedule. The SSA specified that 90% of the rate be invoiced when services were delivered, and that the additional 10% be generated following outcomes reporting. In West Riverton, services allowable are determined by the particular type of voucher issued for the client and by the services offered by the submitting provider. Individual services are restricted to clearly defined minimum and maximum time limits and established reimbursement rates. West Riverton provides a detailed account of the voucher and service types, rate schedule, incentive payment conditions, and restrictions in effect for their voucher program

Accountability: West Riverton is managing performance of ATR providers through outcomes monitoring, including tracking outcomes in SAMHSA's seven identified domains. The SSA monitors provider reporting of outcomes information on a monthly basis. At the end of the first 6 months of the first year, the SSA recognized six providers needed technical assistance to accurately report outcomes information. The SSA provided such technical assistance in a timely manner. At the end of the first year, however, four of the six providers were still unable to provide the outcomes information in each of the seven domains. As a result, West Riverton declared these four providers ineligible for the voucher program for the next year.

The SSA of West Riverton is utilizing a variety of administrative controls to safeguard potential fraud and abuse. An independent auditor will conduct a yearly audit pursuant to OMB Circular No. A-133. Unique client identification numbers will assure there is no duplication of services and payments. On-site audits will be done to assess the need for culturally competent services. Satisfaction surveys will be given to clients. All certified care providers will have to be recertified on a yearly basis. Program monitors will conduct random site visits twice a year to review client files and provider documentation. All client data will be tracked electronically.

Example 2: Eagle Band Tribal Organization

Grant Award Date: August, 2010
Implementation Date: December, 2010
Client Target for Year 1: 800
Client Target for Year 2: 1,500
Client Target for Year 3: 1,500
Client Target for Year 4: 950

Area of Focus: The Eagle Band Tribal Organization is implementing its ATR project in five designated counties between Arizona and New Mexico.

Populations of Focus: The Eagle Band Tribal Organization is using Access to Recovery (ATR) to expand services to rural- and urban-dwelling American Indian/Alaska Natives (AI/AN) residing in Arizona and New Mexico.

Outreach to Providers: Prior to launching its voucher program, Eagle Band conducted outreach to a wide range of substance abuse service providers—both those involved in clinical treatment and those involved in recovery support services. Outreach to enroll new clinical treatment and recovery support service providers included recruitment meetings, mass mailings, in-service trainings, public service announcements, and displays at conferences. Eagle Band recognized it had to set a minimum level of eligibility criteria and standards for each provider within the clinical treatment and recovery support services network to provide quality treatment services to its citizens. Eagle Band encouraged providers to become eligible organizations, explaining that the program would be most successful if clients have access to a variety of treatment and recovery service choices.

Prior to implementation, Eagle Band recruited 48 Tribal Councils and Indian Health provider organizations that provided resolutions demonstrating an interest in joining the ATR provider referral list. Clinical treatment providers must be licensed and/or certified. Recovery support service providers (such as healers or elders) must be in good standing with their respective tribal organization. Two major eligibility conditions were required of providers: 1) all providers must comply with Eagle Band established ATR eligibility standards; and 2) agreeing to provide the required outcomes (the SAMHSA required seven domains) and financial data. Nontraditional providers unable to meet eligibility standards receive technical assistance and training to help them meet the requirements. Faith-based and Native Healing programs that have the ability to provide clinical treatment services will receive assistance for achieving licensure. The Eagle Band Spiritual Healing Association (EBSHA) will have responsibility for certifying unlicensed faith-based organizations wishing to provide recovery support services. An Outreach Coordinator position has been created to conduct outreach and marketing to providers previously unable to compete for Federal funds, including Healing and other faith-based and community organizations.

Eagle Band uses initial educational meetings to introduce the concept of ATR, provider enrollment information, and information about the recovery support services ATR vouchers will support. Enrollment meetings are utilized to enroll recovery support providers, to distribute the eligibility requirements for participation, and to offer help to providers for attaining eligibility standards required for ATR participation. Organizing these events has been an efficient way for Eagle Band to disseminate information and to answer questions and concerns posed by recovery support service providers.

Outreach to Clients:

With ATR, clients would receive vouchers to redeem at the providers of their choice. To recruit clients, Eagle Band is conducting significant outreach in a number of ways. Eagle Band is using a broad range of professional and community sources including self-referral, family, friends, self-help organizations, Tribal organizations, Tribal elders, Healers, faith-based organizations, human service organizations and professionals, health care professionals and centers, community-based organizations, employers, educational institutions, substance abuse treatment facilities, and recovery management services. The Eagle Band Coalition established an 800 information number and a 24-hour access hotline through which certified addiction professionals conduct screenings, thereby facilitating access to clinical treatment and/or recovery support services.

How vouchers are issued:

Assessment voucher: The screening yields the assessment voucher. At the scheduled time, the client is assessed by qualified and trained staff. The assessment includes the Addiction Severity Index (ASI).

Clinical treatment voucher: Based on the results of the comprehensive assessment, a clinical treatment voucher is generated which includes level of care recommendations and all providers that offer the type and level of care indicated by the assessment. The automated voucher system enables the assessor to help the client compare various clinical treatment providers' services and capabilities so the client can make an informed choice. The clinical treatment voucher will contain the client's and assessor's signatures along with the client's choice of provider, clear instructions for the client's next steps – admission date, transportation arrangements (if needed), pre-treatment supports, recovery supports, etc.

Recovery support service voucher: An assessment provider offers multiple choices to the client in terms of recovery supports while awaiting clinical treatment, during clinical treatment, and during extended treatment along with clear instructions about next steps. The assessment produces a recovery supports voucher which includes services that might benefit the client based upon information gathered in the assessment. After the client chooses recovery supports, the client and assessor sign the voucher. The recovery supports voucher may be updated as the need for additional services arises during the course of the recovery process and in preparation for discharge.

Accountability:

Eagle Band put processes in place to prevent, detect, and investigate incidents of fraud and/or potential abuse. Since Eagle Band is using electronic tracking systems, ATR clients will be cross-referenced against other public data systems to identify the receipt of duplicative services and potential payments for the same service by more than one payer. Eagle Band plans to conduct random audits of provider billings and service data. Eagle Band will also be conducting on-site audits to assess the need for culturally competent services. Eagle Band required an initial review of provider service and billing practices before a provider was eligible to participate in ATR. In addition, Eagle Band will be utilizing client satisfaction surveys and medical chart and claims payment audits to reduce the likelihood of waste, fraud and abuse.

Eagle Band monitored provider reporting of outcomes information on a monthly basis. At the end of the first 6 months of the first year, Eagle Band recognized ten providers needed technical assistance to accurately report outcomes information. Eagle Band provided such technical assistance in a timely manner. At the end of the first year, however, four of the ten providers were still unable to provide the outcomes information in each of the seven domains. As a result, Eagle Band declared these four providers ineligible for the ATR voucher program for the next year.

Appendix B – Implementation Components for New and Previously ATR-Funded Applicants

If awarded an ATR III grant, new applicants will be expected to fully implement the project within four months.

If awarded an ATR III grant, previously ATR-funded applicants (under the 2004 and/or 2007 ATR grant programs) will be expected to fully implement the project within three months.

Implementation for ATR projects involves having all of the following components in place and operational:

- Has developed and is operating a fully functioning electronic voucher management system capable of issuing and tracking vouchers.
- Has enrolled and trained network of both clinical treatment and recovery support service providers, including faith-based organizations capable of serving ATR clients. (Based on ATR I and II data, approximately 47% of all providers redeeming vouchers were recovery support service providers, and approximately 35% of all providers redeeming vouchers were faith-based organizations.)
- Has enrolled and is serving clients.
- Is uploading Federally mandated GPRA data at required intervals and within required timelines.
- Has submitted to SAMHSA Government Project Officer (GPO) signed Memoranda of Understanding (MOU) if SSA/Tribe/Tribal Organization is proposing to establish referrals from major institutional systems (Drug Courts, Department of Corrections, Child Protective Services, etc.) into ATR. One MOU should be established with each institutional system and should include specific details about referral pathways, how the two systems will partner, and potential number of referrals into ATR services. See **Appendix L** for a sample MOU.

In addition, full implementation means that the grantee has the capability to:

- Make eligibility determinations for clients and providers.
- Manage and monitor a voucher program.
- Set reimbursement rates and monitor costs per person served.
- Collect and report data (either through an existing or planned system).
- Implement quality improvement activities including technical assistance and training.
- Establish and implement standards for clinical treatment and/or recovery support service providers.
- Conduct screening and assessment and issue vouchers for clinical treatment and recovery support services based on established criteria.
- Provide a list of eligible providers for anyone to whom a voucher is issued.

* Initial Access to Recovery grants were made in August 2004, close to the end of FY 2004. Services are not necessarily provided in the same year Federal funds are obligated. Thus, although the baseline reported for FY 2005 will represent people served in FY 2005, most of the funding will consist of FY 2004 dollars. With the FY 2004 grants, an estimated 125,000 clients will be served over the three year grant period.
1. The first cohort of grantees ends in FY 2007. The second cohort of ATR grantees will begin in FY 2008. Targets for 2008 are lower to allow the new grantees to develop the appropriate infrastructure.

Appendix C – Items Included as Administrative Expenses

- Development of the electronic voucher management system.
- Development of quality improvement activities, including technical assistance and training to attract, develop, and sustain new clinical treatment and recovery support providers.
- Salaries of hired GPRA follow-up data collectors.
- Management of a system for client eligibility determination and assessment for appropriate level of care.
- Eligibility determinations, outreach, recruitment, and enrollment of clinical treatment and recovery services providers in the ATR network including community and faith-based organizations.
- Fiscal/cost accounting mechanisms that can track voucher implementation.
- Management of information systems for tracking outcomes and costs, including the costs of data collection and reporting.
- Marketing of vouchers to client and provider organizations.
- Oversight of standards and fraud and abuse issues.

Appendix D – Checklist for Formatting Requirements and Screenout Criteria for SAMHSA Grant Applications

SAMHSA's goal is to review all applications submitted for grant funding. However, this goal must be balanced against SAMHSA's obligation to ensure equitable treatment of applications. For this reason, SAMHSA has established certain formatting requirements for its applications. **If you do not adhere to these requirements, your application will be screened out and returned to you without review.**

- Use the PHS 5161-1 application form.
- Applications must be received by the application due date and time, as detailed in Section IV-3 of this grant announcement.
- Information provided must be sufficient for review.
- Text must be legible. Pages must be typed in black ink, single-spaced, using a font of Times New Roman 12, with all margins (left, right, top, bottom) at least one inch each. (For Project Narratives submitted electronically, see separate requirements in Section IV-6 of this announcement under "Submission of Electronic Applications.")
- To ensure equity among applications, page limits for the Project Narrative cannot be exceeded.
- Paper must be white paper and 8.5 inches by 11.0 inches in size.

To facilitate review of your application, follow these additional guidelines. Failure to adhere to the following guidelines will not, in itself, result in your application being screened out and returned without review. However, the information provided in your application must be sufficient for review. Following these guidelines will help ensure your application is complete, and will help reviewers to consider your application.

- The application components required for SAMHSA applications should be included and submitted in the following order:
    - Face Page (Standard Form 424 v2, which is in PHS 5161-1)
    - Abstract
    - Table of Contents
    - Budget Form (Standard Form 424A, which is in PHS 5161-1)
    - Project Narrative and Supporting Documentation
    - Attachments

- Project/Performance Site Location(s) Form
- Disclosure of Lobbying Activities (Standard Form LLL, which is in PHS 5161-1)
- Checklist (a form in PHS 5161-1)

- Applications should comply with the following requirements:

  - Provisions relating to confidentiality and participant protection specified in Section V-1 of this announcement.
  - Budgetary limitations as specified in Sections I, II, and IV-5 of this announcement.
  - Documentation of nonprofit status as required in the PHS 5161-1.

- Pages should be typed single-spaced in black ink with one column per page. Pages should not have printing on both sides.

- Pages should be numbered consecutively from beginning to end so that information can be located easily during review of the application. The abstract page should be page 1, the table of contents should be page 2, etc. The four pages of Standard form 424 v2 are not to be numbered. Attachments should be labeled and separated from the Project Narrative and budget section, and the pages should be numbered to continue the sequence.

- The page limits for Attachments stated in Section IV-2.2 of this announcement should not be exceeded.

- Send the original application and two copies to the mailing address in Section IV-6 of this document. Please do not use staples, paper clips, and fasteners. Nothing should be attached, stapled, folded, or pasted. Do not use heavy or lightweight paper or any material that cannot be copied using automatic copying machines. Odd-sized and oversized attachments such as posters will not be copied or sent to reviewers. Do not include videotapes, audiotapes, or CD-ROMs.

Appendix F – Guidance for Electronic Submission of Applications

If you would like to submit your application electronically, you may search http://www.Grants.gov for the downloadable application package by the funding announcement number (called the opportunity number) or by the Catalogue of Federal Domestic Assistance (CFDA) number. You can find the CFDA number on the first page of the funding announcement.

You must follow the instructions in the User Guide available at the http://www.Grants.gov apply site, on the Help page. In addition to the User Guide, you may wish to use the following sources for help:

- By e-mail: support@Grants.gov
- By phone: 1-800-518-4726 (1-800-518-GRANTS). The Grants.gov Contact Center is available 24 hours a day, 7 days a week, excluding Federal holidays.

If this is the first time you have submitted an application through Grants.gov, you must complete three separate registration processes before you can submit your application. Allow at least two weeks (10 business days) for these registration processes, prior to submitting your application. The processes are: 1) DUNS Number registration; 2) Central Contractor Registry (CCR) registration; and 3) Grants.gov registration (Get username and password.). **REMINDER: CCR registration expires each year and must be updated annually.**

Please also allow sufficient time for enter your application into Grants.gov. When you submit your application you will receive a notice that your application is being processed and that you will receive two e-mails from Grants.gov. within the next 24-48 hours. One will confirm receipt of the application in Grants.gov and the other will indicate that the application was either successfully validated by the system (with a tracking number) or rejected due to errors. It will also provide instructions that if you do not receive a receipt confirmation **and** a validation confirmation or a rejection e-mail within 48 hours, you must contact Grants.gov directly. Please note that it is incumbent on the applicant to monitor their application to ensure that it is successfully received and validated by Grants.gov. **If your application is not successfully validated by Grants.gov it will not be forwarded to SAMHSA as the receiving institution.**

It is strongly recommended that you submit your grant application using Microsoft Office 2003 products (e.g., Microsoft Word 2003, Microsoft Excel, etc.). The new Microsoft Vista operating system and Microsoft Word 2007 products are not currently accepted by Grants.gov. If you do not have access to Microsoft Office 2003 products, you may submit PDF files. Directions for creating PDF files can be found on the Grants.gov Web site. Use of file formats other than Microsoft Office or PDF may result in your file being unreadable by our staff.

The Project Narrative must be a separate document in the electronic submission. Formatting requirements for SAMHSA grant applications are described in Appendix A of

Appendix E – Sample Budget Table for the ATR Program

NOTE: A narrative justification must accompany your budget table.

Table 1. Personnel Budget

Budget Category	Name	LOE*	Annual Salary	In-kind Costs	Year 1 Budget	Year 2 Budget	Year 3 Budget	Year 4 Budget
Personnel (Must list 4 key staff)								
SSA/Tribal Organization Administrator (all in-kind—5-10% LOE)								
Project Director								
Treatment Coordinator								
IT Coordinator								
Fiscal Coordinator								
Includes state required 5% salary savings								
If salary increases over years, you need to provide us a copy of the policy.								
Total Personnel Costs								
Fringe								
Benefits								
Total Fringe Costs								
Travel (Justify the Purposes)								
In-state travel								
Out-of-state required travel for grantee meetings								
Other								
Total Travel Costs								

Table 2. Project Budget

	Year 1 Budget	Year 2 Budget	Year 3 Budget	Year 4 Budget
Supplies				
Supplies				
Total Supplies Costs				
Contracts				
Consulting and Professional Services				
(Grantees may not contract out assessment and vouchers. Only the implementation and maintenance of the voucher management system may be contracted out.)				
(Need to breakdown by tasks & person in detail; Clearly state the purposes of the contract. SAMHSA reserves its right to request a copy of your contract.)				
Total Contracts Costs				
Other				
Voucher Pool – electronic vouchers (Need to list the major services broken down by clinical and recovery support service provided, etc. Please provide this information in Table 3.)				
(Need to list any costs associated with methamphetamine issues. Please provide this information in Table 4.)				
Rent				
Communications				
Training				

Facilities Operations				
	Year 1 Budget	Year 2 Budget	Year 3 Budget	Year 4 Budget
Total Other Costs				
Total Direct Costs				
Indirect Costs				
Indirect costs (rate in year one: %)				
Indirect costs (rate in year two: %)				
(For future years if the rate expires provide estimates)				
Total				

Table 3. Project Budget Summary for Year 1 of the Grant

Items	**Budget ($)**	**Percent (%)**	**Number of Clients**	**Total Cost**
Administrative Costs *(please list each item below)*				
Other *(please list each item below). Related to Services, but not vouchered*				
Vouchers				
Total				

Table 4. Clients Served/Voucher Pool Breakdown for Year 1 of the Grant

Modality or Service Type	Average Cost using ATR Funds	In-kind Costs	Number of Clients	Total Cost
Clinical Services				
Low intensive outpatient				
High intensive outpatient				
Adolescent residential (12-17yr)				
Adult residential (18-20yr)				
Recovery Support Services				
Transportation				
Care coordination				
Education				
Child Care				
Total				

this announcement. These requirements also apply to applications submitted electronically, with the following exceptions only for Project Narratives submitted electronically in Microsoft Word. These requirements help ensure the accurate transmission and equitable treatment of applications.

- *Text legibility*: Use a font of Times New Roman 12, line spacing of single space, and all margins (left, right, top, bottom) of at least one inch each. Adhering to these standards will help to ensure the accurate transmission of your document.

- *Amount of space allowed for Project Narrative*: The Project Narrative for an electronic submission may not exceed **18,025** words for a new applicant, and **20,600** words for a previously ATR-funded applicant. **If the Project Narrative for an electronic submission exceeds the word limit, the application will be screened out and will not be reviewed.** To determine the number of words in your Project Narrative document in Microsoft Word, select file/properties/statistics.

Keep the Project Narrative as a separate document. Please consolidate all other materials in your application to ensure the fewest possible number of attachments. Be sure to label each file according to its contents, e.g., "Attachments 1-3", "Attachments 4-5."

Ensure all pages in your application are numbered consecutively, with the exception of the standard forms in the PHS-5161 application package. **Documents containing scanned images must also contain page numbers to continue the sequence.** Failure to comply with these requirements may affect the successful transmission and consideration of your application.

Applicants are strongly encouraged to submit their applications to Grants.gov early enough to resolve any unanticipated difficulties prior to the deadline. After you electronically submit your application, you will receive an automatic acknowledgement from Grants.gov that contains a Grants.gov tracking number. It is important that you retain this number. **Receipt of the tracking number is the only indication that Grants.gov has successfully received and validated your application. If you do not receive a Grants.gov tracking number, you may want to contact the Grants.gov help desk for assistance.**

If you are submitting any documentation that cannot be submitted electronically, please send a hard copy to the address below. [SAMHSA no longer requires submission of a signed paper original of the face page (SF 424 v2) or the assurances (SF 424B)]. **You must include the Grants.gov tracking number for your application on these documents. The documents must be received at the following address within 5 business days after your electronic submission.** Delays in receipt of these documents may impact the score your application receives or the ability of your application to be funded.

For United States Postal Service:

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD **20857**
ATTN: Electronic Applications

For other delivery services, change the zip code to 20850.

If you require a phone number for delivery, you may use (240) 276-1199.

Appendix G – Funding Restrictions

SAMHSA grant funds must be used for purposes supported by the program and may not be used to:

- Pay for any lease beyond the project period.

- Provide services to incarcerated populations (defined as those persons in jail, prison, detention facilities, or in custody where they are not free to move about in the community).

- Pay for the purchase or construction of any building or structure to house any part of the program. (Applicants may request up to $75,000 for renovations and alterations of existing facilities, if necessary and appropriate to the project.)

- Provide residential or outpatient treatment services when the facility has not yet been acquired, sited, approved, and met all requirements for human habitation and services provision. (Expansion or enhancement of existing residential services is permissible.)

- Provide inpatient treatment or hospital-based detoxification services. Residential services are not considered to be inpatient or hospital-based services.

- Make direct payments to individuals to induce them to enter prevention or treatment services. However, SAMHSA discretionary grant funds may be used for non-clinical support services (e.g., bus tokens, child care) designed to improve access to and retention in prevention and treatment programs.

- Make direct payments to individuals to encourage attendance and/or attainment of prevention or treatment goals. However, SAMHSA discretionary grant funds may be used for non-cash incentives of up to $20 to encourage attendance and/or attainment of prevention or treatment goals when the incentives are built into the program design and when the incentives are the minimum amount that is deemed necessary to meet program goals. SAMHSA policy allows an individual participant to receive more than one incentive over the course of the program. However, non-cash incentives should be limited to the minimum number of times deemed necessary to achieve program outcomes. A grantee or treatment or prevention provider may also provide up to $20 cash or equivalent (coupons, bus tokens, gifts, child care, and vouchers) to individuals as incentives to participate in required data collection follow up. This amount may be paid for participation in each required interview.

- Food is generally unallowable unless it's an integral part of a conference grant or program specific, e.g., children's program, residential.

- Implement syringe exchange programs, such as the purchase and distribution of syringes and/or needles.

- Pay for pharmacologies for HIV antiretroviral therapy, sexually transmitted diseases (STD)/sexually transmitted illnesses (STI), TB, and hepatitis B and C. Psychotropic drugs may be covered under the ATR grant under time-limited circumstances only when the client presents with co-occurring mental health and substance abuse disorders and has no other means to cover the cost of necessary psychotropic medications. For example, if a client has a 30 day lapse in coverage after release from incarceration and before other forms of payment begin and is otherwise eligible for ATR, ATR funds may be used to pay for the necessary medications.

- Grant funds may not be used to supplant current funding for substance abuse clinical treatment and/or recovery support services.

- No more than 20% of the grant award may be used for administrative purposes for all grantees. The 20% administrative cap is based on a four year average.

SAMHSA will not accept a "research" indirect cost rate. The grantee must use the "other sponsored program rate" or the lowest rate available.

Appendix H – Standards for the Access to Recovery Program

Grantees will be expected to administer their ATR projects in a manner consistent with good management practices. Grantees will have flexibility in establishing standards appropriate and feasible for their service delivery system and target population. However, once Grantees have established standards for participating provider organizations, they are expected to enforce such standards.

In its application, the SSA/Tribe/Tribal Organization should demonstrate how it intends to:

1. **Ensure that clients receive a genuine, free, and independent choice among assessment, placement, clinical treatment, and recovery support services.**

    a. For purposes of this program, choice is defined as a client being able to select among at least two providers which are qualified to provide the services needed by the client, among them at least one provider to which the client has no religious objection.

2. **Ensure that clients receive a clinical assessment and a level of care determination from a qualified person and/or provider organization.**

    a. SSAs/Tribes/Tribal Organizations should describe the qualifications they require of individuals and/or providers that perform assessments and level of care determinations.

    b. SSAs/Tribes/Tribal Organizations should describe steps they will take to prevent potential conflicts of interest among practitioners and/or provider organizations conducting screening, assessment and referral to clinical treatment and/or recovery support services.

3. **Ensure that clients receive appropriate services from clinical treatment and recovery support programs.**

    a. To be eligible for voucher reimbursement, clinical treatment and recovery support programs should meet standards that are required by the State for other providers that provide the same type of services (e.g. residential, outpatient, family support services, etc.).

    b. Each SSA/Tribe/Tribal Organization should document the eligibility requirements and program standards the SSA/Tribe/Tribal Organization intends to use for each of the services proposed to be reimbursed under the voucher program. Eligibility requirements and standards should be documented for services across the entire array of recovery, as described in **Appendix I**, including eligibility requirements and standards for clinical

treatment services and recovery support services. (For example, the SSA/Tribe/Tribal Organization should document its eligibility requirements and standards for specific types of providers such as residential, outpatient, methadone, recovery support services, etc.) In the case of services for which no standards currently exist, the State must describe the process to be used to ensure that individuals receive appropriate services in safe settings from appropriate individuals. States must also describe how they intend to monitor compliance with these standards and/or processes.

4. **Expand the range of clinical treatment and recovery support services providers that meet appropriate standards.**

   a. SSAs/Tribes/Tribal Organizations should describe how they intend to provide technical assistance and training to providers of clinical treatment and recovery services in order for them to meet standards.

5. Ensure that outcome and financial data is reported in a timely manner.

   a. States should describe how they intend to ensure that outcome data are reported, as required in Section I-2.1 of the funding announcement.

Appendix I – Comprehensive Array of Clinical Treatment and Recovery Support Services

Overview:

Research has established that there are many paths to recovery from alcohol and drug problems. Indeed, many resolve their alcohol and drug problems naturally, without any outside intervention. Others recover with the support of self-help groups such as Alcoholics Anonymous, peer-led recovery centers, and/or the faith community. Still others have found recovery through formal clinical treatment interventions. A variety of factors can influence which of these paths is taken successfully. For example, individuals with moderate problems and social support/stability are more apt to recover naturally or with minimal interventions. In contrast, people who seek treatment tend to have more serious problems.

To achieve the best outcomes at the lowest cost, SAMHSA encourages SSAs/Tribes/Tribal Organizations to provide access to a comprehensive array of clinical treatment and recovery support services as described below. Both components – clinical treatment services and recovery support services–are appropriate for many, if not all, individuals who meet the DSM-IV diagnostic criteria for substance dependence. However, not all services and/or interventions are needed by every individual in treatment for or in recovery from substance dependence. Those who meet the diagnostic criteria for substance abuse may require a less comprehensive range of services. In addition, the array of services described below need not be provided by a single entity but can be provided by a consortium of addiction treatment, health, and human service providers.

This array is not specific to any particular philosophy of clinical treatment and recovery, modality, or setting. It is a generic framework within which potential applicants can conceptualize service arrays, service capabilities, and appropriate managerial and administrative processes, including evaluation.

Methods of implementing the components of this array, the staff who deliver each service, the manner and setting in which different services are delivered, etc., should be based on individual assessment and level of care determination that considers 1) the needs of the individual; 2) the extent to which there are clinical treatment services, recovery support services, health, human services, housing, criminal justice supervision, and labor training alternatives in the jurisdiction of authority; and 3) the extent of available resources and agencies linked through coordinated case management.

In many cases, it will be desirable to provide various components of the array simultaneously, with the emphasis changing throughout the clinical treatment and recovery process. For example, in the earlier, acute phase of clinical treatment, heavier emphasis may be placed on clinical treatment services; the emphasis may switch toward recovery support as individuals move through rehabilitation and enter a maintenance

phase of clinical treatment and recovery. In some cases, recovery support services alone will suffice.

Examples of Clinical Treatment and Recovery Support Services

Clinical treatment services are provided by individuals who are licensed, certified, or otherwise credentialed to provide clinical treatment services in the State, often in settings that address specific treatment needs. Examples of clinical treatment services include the following:

- Screening/assessment
- Brief intervention
- Treatment planning
- Detoxification
- Medical care
- Substance abuse education
- Individual counseling
- Group counseling
- Residential treatment
- Pharmacological interventions
- Co-occurring treatment services
- Family/marital counseling
- Case management
- Relapse prevention
- Continuing care (including face-to-face and telephone-based continuing care counseling)
- Alcohol/drug testing
- Family services, including family/marriage counseling and parenting and child development services
- Employment services and job training
- Outreach

Recovery support services are typically provided by paid staff or volunteers familiar with how their communities can support people seeking to live free of alcohol and drugs, and are often peers of those seeking recovery. Some of these services may require reimbursement while others may be available in the community free of charge. Examples of recovery support services include the following:

- Transportation to and from treatment, recovery support activities, employment, etc.
- Employment services and job training
- Case management/individual services coordination, providing linkages with other services (legal services, TANF, social services, food stamps, etc.)
- Outreach
- Relapse prevention

- Housing assistance and services
- Child care
- Family/marriage education
- Peer-to-peer services, mentoring, coaching
- Self-help and support groups, such as 12-step groups, SMART Recovery, Women for Sobriety, etc.
- Life skills
- Spiritual and faith-based support
- Education
- Parent education and child development
- Substance abuse education

Definitions for Recovery Support Services

Transportation

Commuting services are provided to clients who are engaged in treatment- and/or recovery support-related appointments and activities and who have no other means of obtaining transportation. Forms of transportation services may include public transportation or a licensed and insured driver who is affiliated with an eligible program provider.

Employment Services and Job Training

These activities are directed toward improving and maintaining employment. Services include skills assessment and development, job coaching, career exploration or placement, job shadowing or internships, résumé writing, interviewing skills, and tips for retaining a job. Other services include training in a specific skill or trade to assist individuals to prepare for, find, and obtain competitive employment such as skills training, technical skills, vocational assessment, and job referral.

Case Management

Comprehensive medical and social care coordination is provided to clients to identify their needs, plan services, link the services system with the client, monitor service delivery, and evaluate the effort.

Relapse Prevention

These services include identifying a client's current stage of recovery and establishing a recovery plan to identify and manage the relapse warning signs.

Housing Assistance and Services

These services include transitional housing, recovery living centers or homes, supported independent living, sober housing, short-term and emergency or temporary housing, and housing assistance or management. These services provide a safe, clean, and sober environment for adults with substance use disorders. Lengths of stay may vary depending on the form of housing. This assistance also includes helping families in locating and securing affordable and safe housing, as needed. Assistance may include accessing a housing referral service, relocation, tenant/landlord counseling, repair mediation, and other identified housing needs.

Child Care

These services include care and supervision provided to a client's child(ren), less than 14 years of age and for less than 24 hours per day, while the client is participating in treatment and/or recovery support activities. These services must be provided in a manner that complies with State law regarding child care facilities.

Family/Marriage Counseling and Education

Services provided to engage the whole family system to address interpersonal communication, codependency, conflict, marital issues and concerns, parenting issues, family reunification, and strategies to reduce or minimize the negative effects of substance abuse use on the relationship.

Peer-to-Peer Services, Mentoring, Coaching

Mutual assistance in promoting recovery may be offered by other persons who have experienced similar substance abuse challenges. These services focus more on wellness than illness. Mentoring and coaching may include assistance from a professional who provides the client counsel and/or spiritual support, friendship, reinforcement, and constructive example. Mentoring also includes peer mentoring which refers to services that support recovery and are designed and delivered by peers—people who have shared the experiences of addiction recovery. *Recovery support* is included here as an array of activities, resources, relationships, and services designed to assist an individual's integration into the community, participation in treatment, improved functioning or recovery.

Life Skills

Life skills services address activities of daily living, such as budgeting, time management, interpersonal relations, household management, anger management, and other issues.

Spiritual and Faith-based Support

These services assist an individual or group to develop spiritually. Activities might include, but are not limited to, establishing or reestablishing a relationship with a higher power, acquiring skills needed to cope with life-changing incidents, adopting positive values or principles, identifying a sense of purpose and mission for one's life, and achieving serenity and peace of mind. Faith-based services include those provided to clients and using spiritual resources designed to help persons in recovery to integrate better their faith and recovery. Such services are usually provided in a religious or spiritual setting by spiritual leaders or other staff who are knowledgeable about the spiritual values of the community and are equipped to assist individuals in finding spirituality. Services include, but are not limited to, social support and community-engagement services, faith, or spirituality to assist clients with drawing on the resources of their faith tradition and community to support their recovery; mentoring and role modeling; and pastoral or spiritual counseling and guidance.

Education

Supported education services are defined as educational counseling and may include academic counseling, assistance with academic and financial applications, and aptitude and achievement testing to assist in planning services and support. Vocational training and education also provide support for clients pursuing adult basic education, i.e., general education development (GED) and college education.

Parent Education and Child Development

An intervention or treatment provided in a psycho-educational group setting that involves clients and/or their families and facilitates the instruction of evidence-based parenting or child development knowledge skills. Parenting assistance is a service to assist with parenting skills; teach, monitor, and model appropriate discipline strategies and techniques; and provide information and advocacy on child development, age appropriate needs and expectations, parent groups, and other related issues.

Examples of Recovery Support Service Rate Ranges

Table 1. Rate ranges for selected recovery support service types

Recovery support service type	Unit of service	Range
Most common types		
■ Transportation	■ Round trip	■ $10–$14 bus pass
■ Employment services or job training	■ Hour	■ $10–$46.79
■ Case management	■ Hour	■ $10–$56.89
■ Housing assistance or services	■ Daily transitional	■ $25–$33

Recovery support service type	Unit of service	Range
	■ Recovery House (monthly)	■ $1,359–$2,000
■ Child care	■ Hour	■ $3.85–$12
■ Family, marriage counseling, and education	■ Hour (individual)	■ $5–$81.98
■ Peer-to-peer services, mentoring, coaching	■ Hour (individual) ■ Hour (group)	■ $10–$56.89 ■ $15–$20.50
Other		
■ Life skills	■ Hour	■ $25–$30
■ Spiritual and faith-based support	■ Hour	■ $5–$10
■ Education	■ Hour (individual)	■ $20–$25

Appendix J – Screening, Assessment, and Level of Care Determination

Screening

The purpose of screening is to quickly and cost-effectively rule out people without substance abuse problems and to identify the need for specialized substance abuse treatment.

The basic questions asked in the screening process are: 1) is a substance abuse problem present; and 2) does it require specialized care. Although we often think individuals seeking clinical treatment have been previously screened, some individuals seek specialized treatment directly.

If screening suggests an individual probably has a problem likely to require specialized treatment, the next step in the sequence may be thought of as the problem assessment.

Assessment

Assessment is the systematic process of interaction with an individual to observe, elicit, and subsequently assemble the relevant information required to manage his or her problems, both immediately and for the foreseeable future. An assessment gauges which of the available clinical treatment and recovery services options are likely to be most appropriate for the individual being assessed. Hence, assessment must occur prior to any referral of the individual to a particular kind of clinical treatment and/or recovery support service. When the same general approach is applied to all or most clients, assessment may have little impact.

Purpose of Assessment

- To characterize a problem –

  Substance abuse problems differ from person to person, often both in degree and in kind. What should emerge from an assessment is a detailed picture of the particular kind of substance abuse problem manifested by a particular individual at a particular point in time.

  In the absence of a clear, unambiguous picture at initial contact, appropriate decisions regarding care for the present and future may be difficult.

- To characterize an individual –

  Substance abuse problems do not occur in a vacuum. Individuals who manifest them are at least as different from one another as they are from people without substance use disorders.

  Some of these problems may be the result of abuse of drugs or alcohol; some may result in using drugs or alcohol; others may be independent problems. All are important in themselves, requiring assessment, (and often attention), in clinical treatment and/or recovery support programs. Individual characteristics may affect a person's acceptance (and, in consequence, the eventual outcome) of various forms of clinical treatment and/or recovery support services. Thus, detailed knowledge of individual characteristics can help provide the client with a list of appropriate clinical treatment and/or recovery support service options.

- To identify appropriate clinical treatment and/or recovery support service options–

  Assessment prior to clinical treatment and/or recovery support forms the basis on which individuals are provided a list of clinical treatment and/or recovery support options appropriate to their needs.

  Additional information on the individual will need to be gathered by program staff following the selection of a clinical treatment and/or recovery support program to plan the individual's ongoing course of care.

Level of Care Determination

Level of care determination is achieved through the client's selection of clinical treatment and recovery support alternatives that are both available and most likely to facilitate a positive outcome in a particular individual. Level of Care Determination:

- Focuses on matching clinical treatment and/or recovery support services to individual needs within the framework of client choice

- Defines expectations for each stage of care:
  - Acute intervention, including detoxification
  - Rehabilitation
  - Maintenance and relapse prevention

While choice among the various clinical treatment and/or recovery support services options resides with the individual, the assessor is responsible to ensure that the individual is fully conversant with all of the therapeutic alternatives available from eligible providers.

The Level of Care Determination Process

Level of Care determination is a complex matter, requiring consideration of individuals and their substance abuse problems, and knowledge of available clinical treatment and recovery support services by both the assessor and the client.

The following general descriptors of clinical treatment and recovery support services represent the kinds of information most useful to help identify appropriate levels of care and clinical treatment and/or recovery support service options for individuals with substance abuse problems. When presented to clients in every-day language, the following information can assist clients in making an informed choice of the clinical treatment and/or recovery support service option(s) that may meet their needs:

- Philosophy and orientation of the program (e.g., medical model, social model, spiritual model, etc.);
- Stage of substance abuse problem or recovery at which the clinical treatment and/or recovery support service is directed (e.g., detoxification, rehabilitation, maintenance);
- Setting of the program (e.g., inpatient, outpatient, residential) and staffing; and
- Therapeutic approach/type of intervention

Additional Resources for Screening, Assessment, and Level of Care Determination

I. Resources to Implement Screening

In health care, screening is a process to identify people who have, or are at risk for, an illness or disorder. The purpose of screening is to target persons for clinical treatment and/or recovery support services, thus reducing the long-term morbidity and mortality related to the condition. In addition, by intervening early and raising the individual's level of concern about risk factors and substance-related problems, screening for drug and alcohol problems in community settings can reduce subsequent use.

Two types of screening procedures are typically used. The first includes self-report questionnaires and structured interviews; the second, clinical laboratory tests that can detect biochemical changes associated with excessive alcohol consumption or illicit drug use.

A variety of screening instruments are available. The majority of studies and implementation efforts have focused on screening for alcohol problems. The CAGE and AUDIT are the most commonly used screening tools. The DAST has also been used in conjunction with the AUDIT in several projects, where there has been an effort to implement this approach for persons with or at risk for a substance use disorder. Several new instruments have been developed, but not yet rigorously tested, to assess harmful use of either alcohol or drugs (e.g., the CAGE-D, the ASSIST, the TCUDS, the GAIN-QS, the PDES).

Brown, RL and Rounds LA. 1995. Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. *Wisconsin Medical Journal*, 94, 135-140.

Brown R, Leonard T, Saunders LA, et al. (1997). A two-item screening test for alcohol and other drug problems. *Journal of Family Practice*, 44, 151-160.

A bibliography with descriptions and evaluations of various interview, questionnaire, and laboratory test screening approaches is available from Project Cork.

Project Cork. 2002. *CORK Bibliography: Screening Tests.* 2001-2002, 58 Citations. http://www.projectcork.org/bibliographies/data/Bibliography_Screening_Tests.html

Screening instruments have been developed or modified for use with different target populations, notably adolescents, offenders within the criminal justice system, welfare recipients, women, and the elderly. Several have been translated into other languages and have been evaluated for cultural sensitivity. Again, SAMHSA is not requiring a specific instrument or protocol, but choice of instruments or laboratory tests must be justified.

It is well recognized that screening instruments used with adolescents must be developmentally appropriate, valid and reliable, and practical for use in busy medical settings. One example of a brief substance abuse screening instrument recently developed specifically for use with adolescents is the CRAFFT test.

Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. 2002. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Arch Pediatr Adolesc Med.* 156(6): 607-14.

Additional screening tests and procedures targeted at adolescents, including the PDES and the GAIN-QS, are described in these publications:

Winters KC. 1992. Development of an adolescent alcohol and other drug abuse screening scale: Personal Experience Screening Questionnaire. *Addict Behav.* 17(5): 479-90.

Winters KC. 1999. *Screening and Assessing Adolescents For Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 31 DHHS Publication No. (SMA) 99-3282.

Winters KC. 1999. *Treatment of Adolescents With Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 32. DHHS Publication No. (SMA) 99-3283.

Winters KC. 2001. Assessing adolescent substance use problems and other areas of functioning: State of the art. In: PM Monti, SM. Colby, and TA. O'Leary (eds). *Adolescents, Alcohol, and Substance Abuse: Reaching Teens Through Brief Interventions.* New York, Guilford Publications, Inc., pp. 80-108.

Dennis ML 1998. *Global Appraisal of Individual Needs (GAIN) manual: Administration, Scoring and Interpretation,* (Prepared with funds from CSAT TI 11320). Bloomington IL: Lighthouse Publications. http://www.chestnut.org/LI/GAIN/GAIN_QS/index.html

Martino S, Grilo CM, and Fehon DC 2000. Development of the drug abuse screening test for adolescents (DAST-A). *Addictive Behaviors* 25(1): 57-70.

Screening tests and procedures targeted at the elderly are described in these publications:

Blow, F.C. Consensus Panel Chair. 1998. *Substance Abuse Among Older Adults.* Treatment Improvement Protocol (TIP) Series 26. DHHS Publication No. (SMA) 98-3179.

Blow FC and Barry KL. 1999-2000. Advances in alcohol screening and brief intervention with older adults. *Advances in Medical Psychotherapy.* 10:107-124

Screening tests and procedures targeted at persons in the criminal justice system are described in these publications:

Inciardi JA Consensus Panel Chair 1994. *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series 7. DHHS Publication No. (SMA) 94B2076

Peters, RH, Greenbaum, PE, Steinberg, ML, Carter, CR, Ortiz, MM, Fry, BC, Valle, SK. 2000. Effectiveness of screening instruments in detecting substance use disorders among prisoners. *Journal Substance Abuse Treatment*: 18(4): 349-58.

Simpson DD. 2001. Core set of TCU forms. Fort Worth: Texas Christian University, Institute of Behavioral Research. www.ibr.tcu.edu.

Efforts are ongoing to develop methods to better screen people with co-occurring substance use and mental disorders.

II. Assessment Instruments

Substance abuse assessment instruments are designed to determine the precise nature and severity of an individual's problems. Some instruments are also designed to help pinpoint specific diagnoses. While the results of assessment instruments do not necessarily specify the service needs of clients, the data collected from these instruments

can help determine a client's level of care need and, thus, the options of eligible service providers.

- **Adult Assessment Instruments**

  Addiction Severity Index (ASI)
  ASI is a 30 to 40-minute, interviewer-administered instrument that assesses severity of alcohol and drug problems across several domains. The ASI has been tested extensively and used widely for initial client assessments and to measure client progress and outcomes. The ASI should be administered by trained clinicians.
  McLellan, A.T.; Luborsky, L.; O'Brien, C.P.; Woody, G.E. An improved diagnostic instrument for substance abuse patients: The Addiction Severity Index. *J Nerv Ment Dis* 168:26-33, 1980.
  --and/or--
  McLellan, A.T.; Kushner, H.; Metzger, D.; Peters F.; et al. The fifth edition of the Addiction Severity Index. *J Subst Abuse Treat* 9:199-213, 1992.

  Substance Use Disorders Diagnostic Schedule (SUDDS-IV)
  "The SUDDS-IV is a comprehensive diagnostic assessment interview providing definitive documentation for substance-specific abuse or dependence diagnoses based on DSM-IV-TR criteria. It also screens for depression and anxiety disorders. In addition to diagnostic documentation, the SUDDS-IV provides valuable information for treatment planning and patient placement." (Source: www.evinceassessment.com)
  Harrison, P. & Hoffman, N. (1987). Substance Use Disorders Diagnostic Schedule (SUDDS). St. Paul, MN: Norman G. Hoffman.

  Minnesota Multiphasic Personality Inventory (MMPI)
  "The Minnesota Multiphasic Personality Inventory (MMPI) is an objective verbal inventory designed as a personality test for the assessment of psychopathology consisting of 550 statements, 16 of which are repeated. The replicated statements were originally included to facilitate the first attempt at scanner scoring. Though they are no longer needed for this purpose, they persist in the inventory." (Source: http://www.cps.nova.edu/~cpphelp/MMPI-2.html)
  Hathaway, S. & McKinley, J. Manual for the Minnesota Multiphasic Personality Inventory. New York: Psychological Corporation; 1951, 1967, 1983.
  --and/or--
  Hathaway, S.; McKinley, J.; Butcher, J.; Dahlstrom, W.; Graham, J.; Tellegen, A.; et al. Minnesota Multiphasic Personality Inventory-2: manual for administration. Minneapolis: University of Minnesota Press; 1989.

  The Recovery Attitude and Treatment Evaluator (RAATE)
  "The RAATE-CE and QI instruments were designed to assist in placing patients into the appropriate level of care at admission, in making continued stay or transfer decisions during treatment (utilization review), and documenting

appropriateness of discharge. Both instruments demonstrate good face and rational-expert content validity." (Source: NIAAA)
Mee-Lee, D. An instrument for treatment progress and matching: The Recovery Attitude and Treatment Evaluator (RAATE). *J Subst Abuse Treat* 5:183-186, 1988.
--and/or--
Mee-Lee, D.; Hoffmann, N.G.; and Smith, M.B. *The Recovery Attitude And Treatment Evaluator Manual.* St. Paul, Minnesota: New Standards, Inc., 1992.

- **Adolescent Assessment Instruments**

Comprehensive Adolescent Severity Inventory (CASI)
CASI measures education, substance use, use of free time, leisure activities, peer relationships, family history and intrafamilial substance use, psychiatric status, and legal history. The CASI also incorporates results from urine drug screens and observations from the assessor. Psychometric studies on the CASI support the instrument's reliability and validity.
Meyers, Kathleen. *Comprehensive Adolescent Severity Inventory (CASI).* Philadelphia, PA: Penn/VA Center for Studies of Addiction, 1996. c. 176 p. [RJ 503.7 M4 1996]

Global Assessment of Individual Needs (GAIN)

Dennis, ML 1998. *Global Appraisal of Individual Needs (GAIN) manual: Administration, Scoring and Interpretation,* (Prepared with funds from CSAT TI 11320). Bloomington IL: Lighthouse Publications.
http://www.chestnut.org/LI/GAIN/GAIN_QS/index.html

Winters, KC. 1999. *Screening and Assessing Adolescents For Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 31 DHHS Publication No. (SMA) 99-3282.

III. Diagnostic Criteria

Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition **(DSM-IV)**
DSM-IV includes the most widely accepted criteria for diagnosing substance abuse and mental disorders. Based on data collected during an assessment, the DSM criteria for substance use disorders can be used to determine if someone has a "substance abuse" or "substance dependence" diagnosis. DSM-IV was first published in 1994 by the American Psychiatric Association, Washington D.C.

IV. Level of Care Determination, Continued Stay, and Discharge Criteria

Patient Placement Criteria for the Treatment of Substance-Related Disorders
The American Society of Addiction Medicine (ASAM) published the second edition of its *Patient Placement Criteria for the Treatment of Substance-Related Disorders* (ASAM PPC-2) in 1996. ASAM's PPC-2R presents the criteria for determining which level of services best fits a client's needs. The PPC-2R now has both adult and adolescent criteria and the appropriate criteria should be used for each of these groups.

RAATE

"The RAATE-CE and QI instruments were designed to assist in placing patients into the appropriate level of care at admission, in making continued stay or transfer decisions during treatment (utilization review), and documenting appropriateness of discharge. Both instruments demonstrate good face and rational-expert content validity." (Source: NIAAA)

Mee-Lee, D. An instrument for treatment progress and matching: The Recovery Attitude and Treatment Evaluator (RAATE). *J Subst Abuse Treat* 5:183-186, 1988.
--and/or--
Mee-Lee, D.; Hoffmann, N.G.; and Smith, M.B. *The Recovery Attitude And Treatment Evaluator Manual.* St. Paul, Minnesota: New Standards, Inc., 1992.

Appendix K – Model Template for Implementation Planning and Tracking

Task Name	Duration Total Number of Days	Start Date	Finish Date	Responsible Member of ATR Key Staff or Other Staff	Accomplished by Target Date? (Yes/No)	If No, list cause of delay and when task will be accomplished
Internal Administrative Actions	**Total Number of Days**					
Develop Project Implementation Plan						
Hire full-time permanent IT Coordinator						
Hire full-time permanent Fiscal Coordinator						
Develop MOU with Department of Correction						
Develop MOU with Child Protective Services						
Develop MOUs with community providers						
Set and finalize clinical treatment definitions and rates						
Set and finalize RSS definitions and rates						
Grants and Contracts Management						
Finalize Contract I: Development and Hosting of Voucher Management System						
Develop information management service						
Train the trainers						
Finalize Contract II: TA to treatment and recovery support service providers and potential network members						
Develop strategies for determining provider TA needs						
Identify methods of TA (telephonic, web-based, in person, regional events)						

Task Name	Duration Total Number of Days	Start Date	Finish Date	Responsible Member of ATR Key Staff or Other Staff	Accomplished by Target Date? (Yes/No)	If No, list cause of delay and when task will be accomplished
Training for network clinical treatment and recovery support providers						
Develop training schedule						
Develop training curriculum						
Conduct trainings						
Outreach and Recruitment of Treatment and Recovery Support Service Providers						
Structure provider application process						
Finalize provider application template						
Develop provider manual						
Develop training						
Develop communications and marketing to providers Specify strategies						
Modify billing infrastructure						
Conduct provider events						
Enroll providers						
GPRA-related Tasks						
Obtain GPRA Upload certification from SAMHSA						
Additional Tasks						

Appendix L – Sample Memorandum of Understanding

Memorandum of Understanding
NO. B23-56-9-09-1234

This agreement is entered into by and between the San Bando Family and Services Administration, the Division of Mental Health and Addiction, (hereafter referred to as "DMHA") and the San Bando Department of Correction (hereafter referred to as "DOC"), and is executed pursuant to the terms and conditions set forth herein. In consideration of those mutual undertakings and covenants, the parties agree as follows:

I. PURPOSE

This Memorandum of Understanding ("MOU") is entered into by DMHA and the DOC in order that, under a grant from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (SAMHSA/CSAT), the DMHA may provide increased chemical dependency recovery services to certain committed individuals who are being or who have been released from correctional facilities, are re-entering the community, and who are in need of the services provided by the San Bando Access to Recovery program (ATR). The parties agree to the division of responsibilities as outlined in Sections IV, V, VI, and VII.

II. AUTHORITY

The DMHA enters into this MOU pursuant to the authority found in NA 45-34-98(7). The San Bando DOC enters into this MOU pursuant to the authority found in NA -23-54-34(1).

III. TERM OF AGREEMENT

This MOU shall become effective July 1, 2010 and shall remain in effect through September 30, 2013.

IV. RESPONSIBILITIES OF THE DMHA

The DMHA shall have the following responsibilities:

a) The DMHA shall provide chemical dependency recovery ("services") to the following three target populations:
   - Methamphetamine consuming individuals.
   - Women who are pregnant or who have dependent children.
   - Individuals re-entering the community from correctional facilities.

b) The service shall be paid for through ATR vouchers provided by the DMHA to services providers.

c) The services available through the ATR vouchers shall be the following:
   - Detoxification
   - Transportation
   - Relapse prevention
   - Addiction education
   - Housing assistance
   - Peer coaching services
   - Family and marital counseling
   - Employment services
   - Faith-based and/or community-based support
   - Parenting support services
   - Parenting education
   - Supportive education
   - AOD screening
   - Care coordination
   - Clinical assessment
   - Outpatient treatment
   - Independent treatment of co-occurring disorders

d) The DMHA shall ensure that all San Bando ATR program service providers provider culturally sensitive services to the greatest extent appropriate.

e) The DMHA shall be responsible for training all DOC staff in the policies and procedures of the San Bando ATR program with special emphasis on each of the following:
   - Client eligibility
   - Client choice
   - Referral procedure
   - Intake procedure
   - Outcome measures
   - Non-supplantation policy

f) The DMHA shall be responsible for providing any report or information required by SAMHSA/CSAT concerning the San Bando ATR program provided however that the San Bando DOC shall provide the DMHA with the reports and information required under the terms of this memorandum.

V. RESPONSIBILITIES OF THE SAN BANDO DOC

The DOC shall have the following referral policies:

a) Scope of work
   1. The DOC shall refer inmates to the ATR program as a part of their release procedure insofar as those re-entering the community are in need of the above services provided by the ATR program.

2. ATR vouchers shall be provided for inmate who will reside in the following 3 counties upon their release from a State correctional facility: Vanley, Shorum, and West Fallsville counties.
3. San Bando DOC shall identify at least 3,500 inmates being released from State correctional facilities who are in need of chemical dependency recovery services and refer those individuals to the San Bando ATR program.
4. Referred inmates shall meet all of the following qualifications:
    1) The inmates shall reside following release in one of the three counties listed in the above section.
    2) The inmate shall have a history of substance abuse.
    3) The inmate shall have voluntarily expressed a willingness to participate in the San Bando ATR program.
    4) The inmate shall select a care coordination agency from among those available in the county in which the inmate resides or will reside following release.
5. The San Bando DOC shall establish release protocols that provide the ATR care coordinators the ability to conduct the ATR intake interview prior to the inmate's release from a State correctional facility.
6. During the period immediately preceding an inmate's release from a State correctional facility, the San Bando DOC shall refer to the ATR program inmates who meet the above requirements and who have participated in the following DOC programs:
    1) The Recovery from Addiction Program (RAP)
    2) The Sober and Purposeful Life Program (SPLP)
    3) Any other DOC chemical dependency programs or therapeutic communities.

In addition, the San Bando DOC may refer to the ATR program other inmates in the general population of a State correctional facility who are being released if the inmate otherwise meets the referral requirements contained in this MOU.

7. The San Bando DOC shall provide all referred inmates with a list of approved care coordinators for the ATR program in the county where the inmate will reside following release and shall allow the inmates to select a care coordinator from that list.
8. The San Bando DOC shall assure that no one influences the inmates' selections of a care coordinator from a care coordinator list.
9. The San Bando DOC agrees to provide the ATR care coordinator selected by an inmate with access to the inmate prior to the inmate's release from the State correctional facility.

b). Administrative and funding terms, requirements and limitations

1. The San Bando DOC acknowledges and agrees that no funds will be paid to the San Bando DOC for the purpose of performing the work related to the ATR program as outlined in the preceding scope of work.
2. Each quarter, the San Bando DOC shall provide the DMHA with projections of the individuals to be referred to the ATR program in each successive 6-month period, including the following:
    a. Name
    b. Facility at time of release
    c. County of release
    d. Date of release
    e. Sample matching data
    f. Re-entry coordinator and contact information
3. The San Bando DOC shall provide quarterly reports of the following to the DMHA:
    a. A comparison of (1) the recidivism rate of individuals referred to the ATR program with (2) the recidivism rate of a matched sample of individuals not referred to the program.
    b. The associated savings to the jurisdiction of San Bando.

VI. MUTUAL RESPONSIBILITIES

Each party shall cooperate with the other party and meet with the other party as necessary to further the objectives of this memorandum.

Each party agrees to meet regularly and to provide any information or documentation necessary to fulfill the responsibilities of the DMHA or San Bando DOC under this memorandum.

VII. SECURITY AND PRIVACY OF HEALTH INFORMATION

Through this MOU the parties wish to acknowledge their mutual obligations arising under laws and regulations of the following:

- Health Insurance Portability and Accountability Act of 1996 (HIPPA), Privacy Regulations effective April 14, 2003, and Security Regulations effective on April 20, 2005; and (2) Confidentiality of Alcohol and Drug Abuse Patient Records (CADAPR). 45 CFR 164. 42 CFR 2.

The DMHA agrees to comply with all requirements of HIPPA and CADAPR in all activities related to the MOU, to maintain compliance throughout the life of the MOU, to operate any systems used to fulfill the requirements of this MOU in full compliance with HIPPA and CADAPR and to take no action which adversely affects San Bando's compliance with either Federal statute.

To the extent required by the provisions of HIPPA and regulations promulgated thereunder, the DMHA assures that it will appropriately safeguard Protected Health

Information (PHI), as defined by the regulations, which is made available to or obtained by the DMHA in the course of its work under the MOU. For the purposes of this MOU the term PHI shall include the protections under both 45 CFR 164 and 42 CFR 2. The DMHA agrees to comply with all applicable requirements of law relating to PHI with respect to any task or other activity it performs under this MOU, including the following:

- Implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI that the DMHA receives, maintains, or transmits on behalf of the San Bando DOC;
- Not using or further disclosing PHI other than as permitted or required by this MOU or by applicable law;
- Using appropriate safeguards to prevent use or disclosure of PHI other than as provided by this MOU or by applicable law;
- Mitigating, to the extent practicable, any harmful effect that is known to the DMHA;
- Ensuring that any sub-contractors or agents to whom the DMHA provides PHI received from the San Bando DOC agree to the same restrictions, conditions, and obligations applicable to such party regarding PHI and agrees to implement reasonable and appropriate safeguards to protect it;
- Making available the information required to provide an accounting of disclosures pursuant to applicable law;
- At the termination of the MOU the protections in this agreement shall continue to be extended to any PHI maintained by the DMHA for as long as it is maintained.

The parties agree that all terms in this section of the MOU not otherwise defined shall be defined by reference to the same terms in the HIPPA in its implementing regulations.

VIII. MODIFICATION

This memorandum may be modified at any time by a written modification mutually agreed upon by both agencies.

IX. EFFECTIVE DATE

This memorandum of understanding is effective on the date that both signatories have executed this document.

The parties, having read and understood the terms of this memorandum do, by their respective signatures below, hereby agree to the terms and conditions thereof.

X. NON-COLLUSION AND ACCEPTANCE

The undersigned attests, subject to the penalties for perjury, that he/she is the agreeing party, or that he/she is the representative, agent, member or officer of the agreeing party, that he/she has not, nor has any other member, employee, representative, agent or officer of the division, firm, company, corporation or partnership representative by him/her, directly or indirectly, to the best of his/her knowledge, entered into or offered to enter into any combination, collusion or agreement to receive or pay, and that he/she has not received or paid, any sum of money or other consideration for the execution of this agreement other than that which appears upon the face of the agreement.

XI. SIGNATURES

In Witness Whereof, DMHA and DOC have, through dually authorized representatives entered into this agreement. The parties having read and understand the foregoing terms of the Agreement do by their respective signatures dated below hereby agree to the terms thereof.

San Bando Department of Correction

_____
Commissioner
Date:_____

San Bando Division of Mental Health and Addiction

_____
Director
Date:_____

San Bando Budget Agency

_____
Director
Date:_____

Appendix M – Managing on the Basis of Reasonable Costs

SSAs/Tribes/Tribal Organizations are encouraged to manage the program on the basis of reasonable costs. Proposed per person costs for treatment and recovery support services to be provided under this initiative should be included in the application. In cases where it is not possible to include costs that are based on prior experience, the application should include an estimate of the cost of the service, as well as a plan and timeline for developing cost data based on experience.

The following are considered reasonable ranges by treatment or modality:

- Screening/Brief Intervention/Brief Treatment/Outreach/Pretreatment Services - $200 to $1,200
- Outpatient (Non-Methadone) - $1,000 to $5,000
- Outpatient (Methadone) - $1,500 to $8,000
- Intensive Outpatient- $1,000 to $7,500
- Residential - $3,000 to $10,000
- Peer Recovery Support Services- $1,000 to $2,500

If the SSA/Tribe/Tribal Organization deviates from these costs, it should provide a justification for doing so, in order for SAMHSA to determine reasonableness of costs. Reasonable cost is based on actual cost of providing such services, including direct and indirect cost of providers and excluding any costs that are unnecessary in the efficient delivery of services covered by the program (Center for Medicare and Medicaid Services, 2003). While cost ranges for recovery support services are not specified above, due to the great variations that exist, applicants are expected to provide costs for recovery support services that they intend to provide. Per person costs for each modality should be computed by dividing the number of persons served in each modality by the amount of the project budget used to fund that program component after subtracting out the costs of required data collection and submission.

Appendix N – Past Performance Scoring Sheet for Application Reviewers

The following describes the point structure to be used to award points to applications based on past performance.

For those applicants who received ONLY an ATR 1 award (and not ATR II award), the following point structure will be employed. This structure will be used for EACH year of the grant for a total of three years and a maximum of fifteen points (e.g., 2.5 points X 3 years for percent of client target met = 7.5 points; 2.5 points X 3 years for percent of dollars expended = 7.5 points; 7.5 + 7.5 = 15 points maximum).

Percent of Client Target Met	Number of Points Awarded
80%+	2.5
75%-79.9%	2
70%-74.9%	1.5
65%-69.9%	1
0%-64.9%	.5

Percent of Dollars Expended	Number of Points Awarded
80%+	2.5
75%-79.9%	2
70%-74.9%	1.5
65%-69.9%	1
60%-64.9%	.5

For those applicants who received an ATR II award, the following point structure will be employed. This structure will be used for each COMPLETED year of the grant for a total of two years and fifteen available points.*

Percent of Client Target Met	Number of Points Awarded
80%+	3.75
75%-79.9%	3
70%-74.9%	2.5
65%-69.9%	.5
60%-64.9%	.75

Percent of Dollars Expended	Number of Points Awarded
80%+	3.75
75%-79.9%	3
70%-74.9%	2.5
65%-69.9%	1.5
60%-64.9%	.75

**For applicants who received an ATR 1 and ATR II award, only ATR II performance will be used.*